

unless the violations pose a serious risk to residents, are recurring or have been uncorrected.

(b) When violations of this chapter pose a serious risk to a resident, are recurring or have been uncorrected, the department shall impose a remedy or remedies listed under subsection (3)(a). In determining which remedy or remedies to impose, the department shall take into account the severity of the impact of the violations on residents and which remedy or remedies are likely to improve resident outcomes and satisfaction in a timely manner.

(3)(a) Actions and remedies the department may impose include:

(i) Refusal to enter into a contract;

(ii) Imposition of reasonable conditions on a contract, such as correction within a specified time, training, and limits on the type of clients the provider may admit or serve;

(iii) Imposition of civil penalties of not more than one hundred dollars per day per violation;

(iv) Suspension, termination, or refusal to renew a contract; or

(v) Order stop placement of persons under the contract.

(b) When the department orders stop placement, the facility shall not admit any person under the contract until the stop placement order is terminated. The department may approve readmission of a resident to the facility from a hospital or nursing home during the stop placement. The department shall terminate the stop placement when the department determines that:

(i) The violations necessitating the stop placement have been corrected; and

(ii) The provider exhibits the capacity to maintain adequate care and service.

(c) Conditions the department may impose on a contract include, but are not limited to the following:

(i) Correction within a specified time;

(ii) Training related to the violations; and

(iii) Discharge of any resident when the department determines discharge is needed to meet that resident's needs or for the protection of other residents.

(d) When a contractor fails to pay a fine when due under this chapter, the department may, in addition to other remedies, withhold an amount equal to the fine plus interest, if any, from the contract payment.

[Statutory Authority: RCW 74.39A.010, 74.39A.020 and 74.39A.080. 96-21-050, § 388-110-260, filed 10/11/96, effective 11/11/96. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-260, filed 5/8/96, effective 6/8/96.]

WAC 388-110-270 Notice, hearing rights, effective dates relating to imposition of remedies. (1) Chapter 34.05 RCW applies to department actions under this chapter and chapter 74.39A RCW, except that orders of the department imposing contracts suspension, stop placement, or conditions for continuation of a contract are effective immediately upon notice and shall continue pending any hearing.

(2) Civil monetary penalties shall become due twenty eight days after the contractor is served with a notice of the penalty unless the contractor requests a hearing in compliance with chapter 34.05 RCW and RCW 43.20A.215. If a hearing is requested, the penalty becomes due ten days after a

final decision in the department's favor is issued. Interest shall accrue beginning thirty days after the department serves the contractor with notice of the penalty at a rate of one percent per month in accordance with RCW 43.20B.695.

(3) A person contesting any decision by the department to impose a remedy shall within twenty-eight days of receipt of the decision:

(a) File a written application for an adjudicative proceeding by a method showing proof of receipt with the Office of Appeals, PO Box 2465, Olympia, WA 98504; and

(b) Include in or with the application:

(i) The grounds for contesting the department decision; and

(ii) A copy of the contested department decision.

(4) Administrative proceedings shall be governed by chapter 34.05 RCW, RCW 43.20A.215, where applicable, this section, and chapter 388-08 WAC. If any provision in this section conflicts with chapter 388-08 WAC, the provision in this section governs.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-270, filed 5/8/96, effective 6/8/96.]

WAC 388-110-280 Dispute resolution. (1) When a contractor disagrees with the department's finding of a violation under this chapter, the contractor shall have the right to have the violation reviewed under the department's dispute resolution process. Requests for review shall be made to the department within ten days of receipt of the written finding of a violation.

(2) When requested by a contractor, the department shall expedite the dispute resolution process to review violations upon which a department order imposing contract suspension, stop placement, or a contract condition is based.

(3) Orders of the department imposing contracts suspension, stop placement, or conditions for continuation of a contract are effective immediately upon notice and shall continue pending dispute resolution.

[Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-280, filed 5/8/96, effective 6/8/96.]

Chapter 388-150 WAC

MINIMUM LICENSING REQUIREMENTS FOR CHILD DAY CARE CENTERS

WAC

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WAC 388-150-005 Authority. The following rules are adopted under chapters 74.12 and 74.15 RCW.

[Statutory Authority: RCW 74.12.340, 94-13-201 (Order 3745), § 388-150-005, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030, 91-07-013 (Order 3151), § 388-150-005, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-005, filed 11/20/90, effective 12/21/90.]

WAC 388-150-010 Definitions. As used and defined under this chapter:

"Capacity" means the maximum number of children the licensee is authorized to have on the premises at a given time.

"Center" means the same as **"child day care center."**

"Child abuse or neglect" means the injury, sexual abuse, sexual exploitation, or negligent treatment or maltreatment of a child by any person under circumstances indicating the child's health, welfare, and safety is harmed thereby.

"Child day care center" means a facility providing regularly scheduled care for a group of children one month of age through twelve years of age for periods less than twenty-four hours; except, a program meeting the definition of a family child care home shall not be licensed as a day care center without meeting the requirements of WAC 388-150-020 (5)(a).

"Department" means the state department of social and health services.

"Department of health" means the state department of health.

"Infant" means a child eleven months of age and under.

"License" means a permit issued by the department authorizing by law the licensee to operate a child day care center and certifying the licensee meets minimum requirements under licensure.

"Licensee" means the person, organization, or legal entity responsible for operating the center.

"Premises" means the building where the center is located and the adjoining grounds over which the licensee has control.

"Preschool age child" means a child thirty months of age through five years of age not enrolled in kindergarten or an elementary school.

"School-age child" means a child five years of age through twelve years of age enrolled in kindergarten or an elementary school.

"Staff" means a child care giver or a group of child care givers employed by the licensee to supervise a child served at the center.

"Toddler" means a child twelve months of age through twenty-nine months of age.

"The Washington state training and registry system (STARS)" means the entity approved by the department to determine the classes, courses, and workshops licensees and staff may take to satisfy training requirements.

[Statutory Authority: RCW 74.15.030, 98-24-052, § 388-150-010, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-010, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-010, filed 11/20/90, effective 12/21/90.]

WAC 388-150-020 Scope of licensing. (1) The person or organization operating a child day care center shall be subject to licensing by authority under chapter 74.15 RCW, unless specifically exempted by RCW 74.15.020(4).

(2) The person or organization operating a child day care center and qualifying for exemption from requirements of this chapter under RCW 74.15.020(4) shall not be subject to licensure. The person or organization claiming an exemption shall provide the department proof of entitlement to the exemption on the department's request.

(3) RCW 74.15.020 (4)(c) exempts from licensing facilities where parents on a mutually cooperative basis exchange care of one another's children. To qualify for this cooperative exemption:

(a) At least one parent or guardian of each child attending the facility regularly shall be involved in the direct care of children at the facility;

(b) Parents or guardians shall be involved in the direct care of children on a relatively equal basis; and

(c) A person other than a parent or guardian of a child at the facility shall not be involved in the care of children or in the operation of the facility.

(4) The department shall not license the center legally exempt from licensing. However, at the applicant's request, the department shall investigate and may certify the center as meeting licensing and other pertinent requirements. In such

cases, the department's requirements and procedures for licensure shall apply equally to certification.

(5) The department may certify a day care center for payment without further investigation if the center is:

- (a) Licensed by an Indian tribe;
- (b) Certified by the Federal Department of Defense; or

(c) Approved by the superintendent of public instruction's office. The center must be licensed, certified, or approved in accordance with national or state standards or standards approved by the department and be operated on the premises over which the entity operating the center has jurisdiction.

(6) The department shall not license the department employee or the member of the department employee's household when such person is involved directly, or in an administrative or supervisory capacity, in the:

- (a) Licensing or certification process;
- (b) Placement of a child in a licensed or certified center;

or

- (c) Authorization of payment for the child in care.

(7)(a) The department may license the center located in a private family residence when the portion of the residence accessible to the child is:

(i) Used exclusively for the child during the center's operating hours or while the child is in care; or

- (ii) Separate from the family living quarters.

(b) A child care facility in a separate building on the same premises as a private family residence is a child day care center.

(8) The person or organization desiring to serve state-paid children shall:

- (a) Be licensed or certified;

(b) Follow billing policies and procedures in *Child Day Care Subsidies, A Booklet for Providers*, DSHS 22-877(X); and

(c) Bill the department at the person's or organization's customary rate or the DSHS rate, whichever is less.

[Statutory Authority: RCW 74.12.340, 94-13-201 (Order 3745), § 388-150-020, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-020, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 91-15-084 and 91-21-070 (Orders 3205 and 3205A), § 388-150-020, filed 7/23/91 and 10/17/91, effective 8/23/91 and 11/17/91; 90-23-078 (Order 3103), § 388-150-020, filed 11/20/90, effective 12/21/90.]

WAC 388-150-040 Local ordinances and codes. The department shall issue or deny a license on the basis of the applicant's compliance with minimum licensing and procedural requirements. The department shall notify the local planning office of the applicant's intention to operate a child care center within the local jurisdiction. Local officials shall be responsible for enforcing city ordinances and county codes, such as zoning and building regulations.

[Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-040, filed 11/20/90, effective 12/21/90.]

WAC 388-150-050 Waivers. (1) In an individual case, the department, for good cause, may waive a specific requirement and may approve an alternate method for the licensee or applicant to achieve the specific requirement's intent if the:

(a) Licensee or applicant submits to the department a written waiver request fully explaining the circumstances necessitating the waiver; and

(b) Department determines waiver approval will not jeopardize the safety or welfare of the child in care or detract from the quality of licensee-delivered services.

(2) The department may approve a waiver request only for a specific purpose or child and for a specific period of time not exceeding the expiration date of the license.

(3) The department may limit or restrict a license issued to a licensee or an applicant in conjunction with a waiver.

(4) The licensee shall maintain on the premises a copy of the department's written waiver approval.

(5) The department's denial of a licensee's or applicant's waiver request shall not be subject to appeal under chapter 34.05 RCW.

[Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-050, filed 11/20/90, effective 12/21/90.]

WAC 388-150-060 Dual licensure. The department may either:

(1) Issue a child day care center license to the applicant having a license involving full-time care; or

(2) Permit simultaneous care for the child and adolescent or adult on the same premises if the applicant or licensee:

(a) Demonstrates evidence that care of one client category will not interfere with the quality of services provided to another category of clients;

(b) Maintains the most stringent maximum capacity limitation for the client categories concerned;

(c) Requests and obtains a waiver permitting dual licensure; and

(d) Requests and obtains a waiver to subsection (2)(b) of this section, if applicable.

[Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-060, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-060, filed 11/20/90, effective 12/21/90.]

WAC 388-150-070 Application and reapplication for licensing—Investigation. (1) The person or organization applying for a license or re licensure under this chapter and responsible for operating the center shall comply with application procedures the department prescribes and submit to the department:

(a) A completed department-supplied application for child care agency form, including required attachments, ninety or more days before the:

- (i) Expiration of a current license;
- (ii) Opening date of a new center;
- (iii) Relocation of a center;
- (iv) Change of the licensee; or
- (v) Change of license category.

(b) A completed criminal history and background inquiry form for each staff person or volunteer having unsupervised or regular access to the child in care; and

- (c) The licensing fee.

(2) In addition to the required application materials specified under subsection (1) of this section, the applicant for initial licensure shall submit to the department:

(a) An employment and education resume of the person responsible for the active management of the center and the program supervisor;

(b) Diploma or education transcript copies of the program supervisor; and

(c) Three professional references each for the licensee, director, and program supervisor.

(3) The applicant for a license under this chapter shall be twenty-one years of age or older.

(4) The applicant, licensee, and director shall attend department-provided orientation training.

(5) The department may, at any time, require additional information from the applicant, licensee, staff person, volunteer, member of their households, and other person having access to the child in care as the department deems necessary, including, but not limited to:

- (a) Sexual deviancy evaluations;
- (b) Substance and alcohol abuse evaluations;
- (c) Psychiatric evaluations;
- (d) Psychological evaluations; and
- (e) Medical evaluations.

(6) The department may perform investigations of the applicant, licensee, staff person, volunteer, member of their households, and other person having access to the child in care as the department deems necessary, including accessing criminal histories and law enforcement files.

(7) The applicant shall conform to rules and regulations approved or adopted by the:

(a) Department of health, promoting the health of the child in care, contained in this chapter; and

(b) State fire marshal's office, establishing standards for fire prevention and protection of life and property from fire, under chapter 212-12 WAC, "fire marshal standards."

(8) The department shall not issue a license to the applicant until the department of health and the state fire marshal's office have certified or inspected and approved the center.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-070, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-070, filed 11/20/90, effective 12/21/90.]

WAC 388-150-080 Licensed capacity. (1) The department shall issue the applicant or licensee a license for a specific number of children dependent on the:

(a) Department's evaluation of the center's premises, equipment, and physical accommodations;

(b) Number and skills of the licensee, staff, and volunteers; and

(c) Ages and characteristics of the children served.

(2) The department:

(a) Shall not issue the applicant or licensee a license to care for more children than permitted under this chapter; and

(b) May issue the applicant or licensee a license to care for fewer children than the center's maximum capacity.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-080, filed 11/20/90, effective 12/21/90.]

WAC 388-150-085 Initial license. (1) The department may issue an initial license to an applicant not currently licensed to provide child day care when the applicant:

(1999 Ed.)

(a) Can demonstrate compliance with the rules contained in this chapter pertaining to the health and safety of the child in care; but

(b) Cannot demonstrate compliance with the rules pertaining to:

- (i) Staff-child interactions,
- (ii) Group size and staff-child ratios,
- (iii) Behavior management and discipline,
- (iv) Activity programs,
- (v) Child records and information, and
- (vi) Other rules requiring department observation of the applicant's ability to comply with rules.

(c) Can provide a plan, acceptable to the department, to comply with rules found in subsection (1)(b) of this section.

(2) The department may issue an initial license to an applicant for a period not to exceed six months, renewable for a period not to exceed two years.

(3) The department shall evaluate the applicant's ability to comply with all rules contained in this chapter during the period of initial licensure prior to issuing a full license.

(4) The department may issue a full license to the applicant demonstrating compliance with all rules contained in this chapter at any time during the period of initial licensure.

(5) The department shall not issue a full license to the applicant who does not demonstrate the ability to comply with all rules contained in this chapter during the period of initial licensure.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-085, filed 10/1/96, effective 11/1/96.]

WAC 388-150-090 License denial, suspension, or revocation. (1) Before granting a license and as a condition for continuance of a license, the department shall consider the ability of the applicant and licensee to meet the requirements of this chapter. If more than one person is the applicant or licensee, the department:

(a) Shall consider the persons' qualifications separately and jointly; and

(b) May deny, suspend, revoke, or not renew the license based on the failure of one of the persons to meet the requirements.

(2) The department shall deny, suspend, revoke, or not renew the license of a person who:

(a) Has abused, neglected, or sexually exploited a child as those acts or omissions are defined in RCW 26.44.020 and WAC 388-15-130, is ineligible to provide care because of a criminal history under chapter 388-330 WAC, or allows such a person on the premises;

(b) Commits or was convicted of a felony reasonably related to the competency of the person to meet the requirements of this chapter;

(c) Engages in illegal use of a drug or excessive use of alcohol;

(d) Commits, permits, aids, or abets the commission of an illegal act on the premises;

(e) Commits, permits, aids, or abets the abuse, neglect, exploitation, or cruel or indifferent care to a child in care;

(f) Refuses to permit an authorized representative of the department, state fire marshal, state auditor's office, or department of health to inspect the premises; or

(g) Refuses to permit an authorized representative of the department, the department of health, or state auditor's office access to records related to operation of the center or to interview staff or a child in care.

(3) The department may deny, suspend, revoke, or not renew a license of a person who:

(a) Seeks to obtain or retain a license by fraudulent means or misrepresentation, including, but not limited to:

(i) Making a materially false statement on the application; or

(ii) Omitting material information on the application.

(b) Provides insufficient staff in relation to the number, ages, or characteristics of children in care;

(c) Allows a person unqualified by training, experience, or temperament to care for or be in contact with a child in care;

(d) Violates any condition or limitation on licensure including, but not limited to:

(i) Permitting more children on the premises than the number for which the center is licensed; or

(ii) Permitting on the premises a child of an age different from the ages for which the center is licensed.

(e) Fails to provide adequate supervision to a child in care;

(f) Demonstrates an inability to exercise fiscal responsibility and accountability with respect to operation of the center;

(g) Misappropriates property of a child in care;

(h) Knowingly permits on the premises an employee or volunteer who has made a material misrepresentation on an application for employment or volunteer service;

(i) Refuses or fails to supply necessary, additional department-requested information; or

(j) Fails to comply with any provision of chapter 74.15 RCW or this chapter.

(4) The department shall not issue a license to a person who has had denied, suspended, revoked, or not renewed a license to operate a facility for the care of children or adults, in this state or elsewhere, unless the person demonstrates by clear, cogent, and convincing evidence the person has undertaken sufficient corrective action or rehabilitation to warrant public trust and to operate the center in accordance with the rules of this chapter.

(5) The department's notice of a denial, revocation, suspension, or modification of a license and the applicant's or licensee's right to a hearing is governed under RCW 43.20A.205.

[Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-150-090, filed 4/26/96, effective 5/27/96. Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-150-090, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-090, filed 11/20/90, effective 12/21/90.]

WAC 388-150-092 Civil penalties. (1) Before imposing a civil penalty, the department shall provide written notification by personal service, including by the licensor, or certified mail which shall include:

(a) A description of the violation and citation of the applicable requirement or law;

(b) A statement of what is required to achieve compliance;

(c) The date by which the department requires compliance;

(d) The maximum allowable penalty if timely compliance is not achieved;

(e) The means to contact any technical assistance services provided by the department or others; and

(f) Notice of when, where, and to whom a request to extend the time to achieve compliance for good cause may be filed with the department.

(2) The length of time in which to comply shall depend on:

(a) The seriousness of the violation;

(c) The potential threat to the health, safety and welfare of children in care; or

(c) Previous opportunities to correct the deficiency.

(3) The department may impose a civil penalty based on but not limited to these reasons:

(a) The child care center has previously been subject to an enforcement action for the same or similar type of violation of the same statute or rule; or

(b) The child care center has previously been given notice of the same or similar type of violation of the same statute or rule; or

(c) The violation represents a potential threat to the health, safety, and/or welfare of children in care.

(4) The department may impose a civil penalty in addition to or in conjunction with other disciplinary actions against a child care license including probation, suspension, or other action.

(5) The civil fine shall be payable twenty-eight days after receipt of the notice or later as specified by the department.

(6) The fine may be forgiven if the agency comes into compliance during the notification period.

(7) The center or person against whom the department assesses a civil fine has a right to an adjudicative proceeding as governed by RCW 43.20A.215.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-092, filed 10/1/96, effective 11/1/96.]

WAC 388-150-093 Civil penalties—Amount of penalty. Whenever the department imposes a civil monetary penalty per WAC 388-150-092(3), the department shall impose a penalty of two hundred and fifty dollars per violation per day. The department may assess and collect the penalty with interest for each day of noncompliance.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-093, filed 10/1/96, effective 11/1/96.]

WAC 388-150-094 Civil penalties—Posting of notice of penalty. (1) The licensee shall post the final notice of a civil penalty in a conspicuous place in the facility.

(2) The notice shall remain posted until payment is received by the department.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-094, filed 10/1/96, effective 11/1/96.]

WAC 388-150-095 Civil penalties—Unlicensed programs. Where the department has determined that an agency is operating without a license, the department shall send writ-

ten notification by certified mail or other means showing proof of service. This notification shall contain the following:

(1) Advising the agency of the basis of determination of providing child care without a license and the need to be licensed by the department;

(2) The citation of the applicable law;

(3) The assessment of seventy-five dollars per day penalty of each day unlicensed care is provided. The fine would be effective and payable within thirty days of receipt of the notification;

(4) How to contact the office of child care policy;

(5) The need to submit an application to the office of child care policy within thirty days of receipt of the notification;

(6) That the penalty may be forgiven if the agency submits an application within thirty days of the notification; and

(7) The right of an adjudicative proceeding as a result of the assessment of a monetary penalty and the appropriate procedure for requesting an adjudicative proceeding.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-095, filed 10/1/96, effective 11/1/96.]

WAC 388-150-096 Civil penalties—Separate violations. Each violation of a law or rule constitutes a separate violation and may be penalized as such. A penalty may be imposed as a flat amount of the maximum allowable, or may be imposed for each day the violation continues.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-096, filed 10/1/96, effective 11/1/96.]

WAC 388-150-097 Civil penalties—Penalty for non-payment. Penalty for nonpayment. The department may suspend, revoke or not renew a license for failure to pay a civil monetary penalty it has assessed within ten days after such assessment becomes final.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-097, filed 10/1/96, effective 11/1/96.]

WAC 388-150-098 Probationary license. (1) The department shall base the decision as to whether a probationary license will be issued upon the following factors:

(a) Willful or negligent noncompliance by the licensee,

(b) History of noncompliance,

(c) Extent of deviation from the requirements,

(d) Evidence of a good faith effort to comply,

(e) Any other factors relevant to the unique situation.

(2) Where the negligent or willful violation of the licensing requirements does not present an immediate threat to the health and well-being of the children but would be likely to do so if allowed to continue, a probationary license may be issued as well as civil penalties or other sanctions. Such situations may include:

(a) Substantiation that a child (or children) was abused or neglected while in the care of the center,

(b) Disapproved fire safety or sanitation report,

(c) Use of unauthorized space for child care,

(d) Inadequate supervision of children,

(e) Understaffing for the number of children in care,

(f) Noncompliance with requirements addressing:

(i) Children's health,

(ii) Proper nutrition,

(iii) Discipline,

(iv) Emergency medical plan,

(v) Sanitation and personal hygiene practices.

(3) Licensee required to notify parents when a probationary licensed is issued:

(a) The licensee shall notify the parents or guardians of all children in care that it is in probationary status within five working days of receiving notification he or she has been issued a probationary license;

(b) The notification shall be in writing and shall be approved by the department prior to being sent;

(c) The licensee shall provide documentation to the department that parents or guardians of all children in care have been notified within ten working days of receiving notification that he or she has been issued a probationary license;

(d) The department may issue a probationary license for up to six months, and at the discretion of the department it may be extended for an additional six months.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-150-098, filed 10/1/96, effective 11/1/96.]

WAC 388-150-100 Activity program. (1) The licensee shall implement an activity program designed to meet the developmental, cultural, and individual needs of the child served. The licensee shall ensure the program contains a range of learning experiences for the child to:

(a) Gain self-esteem, self-awareness, self-control, and decision making abilities;

(b) Develop socially, emotionally, intellectually, and physically;

(c) Learn about nutrition, health, and personal safety; and

(d) Experiment, create, and explore.

(2) The licensee shall ensure the center's program offers variety and options, including a balance between:

(a) Child-initiated and staff-initiated activities;

(b) Free play and organized events;

(c) Individual and group activities; and

(d) Quiet and active experiences.

(3) The licensee shall ensure the center's program affords the child daily opportunities for small and large muscle activities and outdoor play.

(4) The licensee shall operate the center's program under a regular schedule of activities with allowances for a variety of special events. The licensee shall implement a planned program of activities as evidenced by a current, written activity schedule, and afford staff classroom planning time.

(5) The licensee shall manage child and staff movements from one planned activity or care area to another to achieve smooth, unregulated transitions by:

(a) Establishing familiar routines;

(b) Contributing to learning experiences; and

(c) Maintaining staff-to-child ratio and group size guidelines.

(6) The child may remain in care only ten hours or less per day except as necessitated by the parent's working hours and travel time from and to the center.

[Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-100, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-100, filed 11/20/90, effective 12/21/90.]

WAC 388-150-110 Learning and play materials. The licensee shall provide the child a variety of easily accessible, developmentally appropriate learning and play materials of sufficient quantity to implement the center's program. The licensee shall ensure material is culturally relevant and promotes:

- (1) Social development;
- (2) Intellectual ability;
- (3) Language development and communication;
- (4) Self-help skills;
- (5) Sensory stimulation;
- (6) Large and small muscle development; and
- (7) Creative expression.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-110, filed 11/20/90, effective 12/21/90.]

WAC 388-150-120 Staff-child interactions. (1) The licensee shall furnish the child a nurturing, respectful, supportive, and responsive environment through frequent interactions between the child and staff:

- (a) Supporting the child in developing an understanding of self and others by assisting the child to share ideas, experiences, and feelings;
- (b) Providing age-appropriate opportunities for intellectual growth and development of the child's social and language skills, including encouraging the child to ask questions;
- (c) Helping the child solve problems;
- (d) Fostering creativity and independence in routine activities, including showing tolerance for mistakes; and
- (e) Treating equally all children in care regardless of race, religion, culture, sex, and handicapping condition.

(2) The licensee shall furnish the child a pleasant and educational environment at meal and snack times. Staff shall provide good models for nutrition habits and social behavior by:

- (a) Sitting and eating with children, when possible; and
- (b) Encouraging conversation among children.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-120, filed 11/20/90, effective 12/21/90.]

WAC 388-150-130 Behavior management and discipline. (1) The licensee shall guide the child's behavior based on an understanding of the individual child's needs and stage of development. The licensee shall promote the child's developmentally appropriate social behavior, self-control, and respect for the rights of others.

(2) The licensee shall ensure behavior management and discipline practices are fair, reasonable, consistent, and related to the child's behavior. Staff shall not administer cruel, unusual, hazardous, frightening, or humiliating discipline.

(3) The licensee shall be responsible for implementing the behavior management and discipline practices of the center. The child in care shall not determine or administer behavior management or discipline.

- (4) The licensee shall prohibit and prevent:
 - (a) Corporal punishment by any person on the premises, including biting, jerking, shaking, spanking, slapping, hitting, striking, or kicking the child, or other means of inflicting physical pain or causing bodily harm;
 - (b) The use of a physical restraint method injurious to the child;
 - (c) The use of a mechanical restraint for disciplinary purposes, locked time-out room, or closet; or
 - (d) The withholding of food as a punishment.
- (5) In emergency situations, the staff person competent to use restraint methods may use limited physical restraint when:
 - (a) Protecting a person on the premises from physical injury;
 - (b) Obtaining possession of a weapon or other dangerous object; or
 - (c) Protecting property from serious damage.
- (6) The licensee shall document any incident involving the use of physical restraint.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-130, filed 11/20/90, effective 12/21/90.]

WAC 388-150-140 Rest periods. (1) The licensee shall offer a supervised rest period to the child:

- (a) Five years of age and under remaining in care more than six hours; or
- (b) Showing a need for rest.
- (2) The licensee shall plan quiet activities for the child not needing rest.
- (3) The licensee shall allow the child twenty-nine months of age or younger to follow an individual sleep schedule.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-140, filed 11/20/90, effective 12/21/90.]

WAC 388-150-150 Evening and nighttime care. (1) For the center offering child care during evening and nighttime hours, the licensee shall adapt the program, equipment, and staffing pattern to meet the physical and emotional needs of the child away from home at night.

(2) The licensee shall maintain the same staff-to-child ratio in effect during daytime care. At all times, including sleeping hours, staff shall keep the child within continuous visual or auditory range.

(3) The licensee shall arrange child grouping so the sleeping child remains asleep during the arrival or departure of another child.

(4) The licensee shall ensure that staff in charge during evening and nighttime hours meet at least the requirements of a lead worker.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-150, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-150, filed 11/20/90, effective 12/21/90.]

WAC 388-150-160 Off-site trips. (1) The licensee may transport or permit the off-site travel of the child to attend school, participate in supervised field trips, or engage in other

supervised off-site activities only with written parent consent.

(2) The parent's consent may be:

(a) For a specific date and trip; or

(b) A blanket authorization describing the full range of trips the child may take. In such case, the licensee shall notify the parent in advance about the trip.

[Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-160, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-160, filed 11/20/90, effective 12/21/90.]

WAC 388-150-165 Transportation. When the licensee provides transportation for the child in care:

(1) The licensee shall ensure that the motor vehicle operated by the facility is maintained in a safe operating condition;

(2) The licensee shall ensure the motor vehicle in which the child rides during hours of care is equipped with appropriate safety devices and individual seat belts or safety seats for each child to use when the vehicle is in motion. The licensee shall assure that children less than two years of age are restrained in a restraint system that complies with standards of the United States department of transportation. Seat belts are not required for buses approved by the state patrol;

(3) The licensee shall ensure the number of passengers does not exceed the seating capacity of the motor vehicle;

(4) The licensee or driver shall carry liability and medical insurance. The driver shall have a current Washington driver's license, valid for the classification of motor vehicle operated;

(5) The driver or staff supervising the child in the motor vehicle shall have current first aid and cardiopulmonary resuscitation training, except that when the center uses more than one vehicle for a field trip, only one person in the group is required to have this training;

(6) The licensee shall ensure a minimum of one staff person, other than the driver, is present in the motor vehicle when:

(a) Seven or more preschool age and younger children are present; or

(b) Staff-to-child ratio guidelines require additional staff.

(7) Staff or driver shall not leave the child unattended in the motor vehicle.

[Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-165, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-165, filed 11/20/90, effective 12/21/90.]

WAC 388-150-170 Parent communication. (1) The licensee shall orally:

(a) Explain to the parent the center's policies and procedures;

(b) Orient the parent to the center's philosophy, program, and facilities;

(c) Advise the parent of the child's progress and issues relating to the child's care and individual practices concerning the child's special needs; and

(d) Encourage parent participation in center activities.

(2) The licensee shall give the parent the following written policy and procedure information:

(a) Enrollment and admission requirements;

(b) The fee and payment plan;

(c) A typical activity schedule, including hours of operation;

(d) Meals and snacks served, including guidelines on food brought from the child's home;

(e) Permission for free access by the child's parent to all center areas used by the child;

(f) Signing in and signing out requirements;

(g) Child abuse reporting law requirements;

(h) Behavior management and discipline;

(i) Nondiscrimination statement;

(j) Religious activities, if any;

(k) Transportation and field trip arrangements;

(l) Practices concerning an ill child;

(m) Medication management;

(n) Medical emergencies; and

(o) If licensed for the care of an infant or toddler:

(i) Diapering;

(ii) Toilet training; and

(iii) Feeding.

[Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-170, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-170, filed 11/20/90, effective 12/21/90.]

WAC 388-150-180 Staff pattern and qualifications.

(1) General qualifications. The licensee, staff, volunteer, and other person associated with the operation of the center who has access to the child in care shall:

(a) Be of good character;

(b) Demonstrate the understanding, ability, personality, emotional stability, and physical health suited to meet the cultural, emotional, mental, physical, and social needs of the child in care; and

(c) Not have committed or been convicted of child abuse or any crime involving harm to another person.

(2) Center management. The licensee shall serve as or employ a director, responsible for the overall management of the center's facility and operation. The director shall:

(a) Be twenty-one years of age or older;

(b) Serve as administrator of the center, ensuring compliance with minimum licensing requirements;

(c) Have knowledge of child development as evidenced by professional references, education, experience, and on-the-job performance;

(d) Have the management and supervisory skills necessary for the proper administration of the center, including:

(i) Record maintenance;

(ii) Financial management; and

(iii) Maintenance of positive relationships with staff, children, parents, and the community;

(e) Have completed the following number of college quarter credits or department-approved clock hours in early childhood education/child development, or possess an equivalent educational background, or be a certified child development associate:

(i) In centers licensed for twenty-five or more children, the director shall have completed forty-five or more credits;

(ii) In centers licensed for thirteen through twenty-four children, the director shall have completed twenty-five or more credits;

(iii) In centers licensed for twelve or fewer children, the director shall have completed ten or more credits; and

(iv) In (i), (ii) and (iii) above, one-third of the credits may be clock hours.

(f) Have two or more years successful experience working with children of the same age level as those served by the center as evidenced by professional references and on-the-job performance;

(g) Have planning, coordination, and supervisory skills to implement a high quality, developmentally appropriate program;

(h) Have knowledge of children and how to meet children's needs; and

(i) Have completed one of the following prior to or within the first six months of employment or initial licensure, except as provided in subsection (2)(j) of this section:

(i) Twenty clock hours or two college quarter credits of basic training approved by the Washington state training registry system (STARS); or

(ii) Current child development associate (CDA) or equivalent credential or twelve or more college quarter credits in early childhood education or child development; or

(iii) Associate of arts or AAS or higher college degree in early childhood education or child development.

(j) Directors who are already employed or licensed on the effective date of this rule must complete the training required in WAC 388-150-180 (2)(i) prior to or within twelve months after the effective date of this rule.

(3) When the director does not meet the qualifications specified in subsections (2)(e), (f), (g), and (h) of this section, the director or licensee shall employ a program supervisor responsible for planning and supervising the center's learning and activity program. In such a case, the director shall have had at least one three credit college class in early childhood development. The program supervisor shall:

(a) Be twenty-one years of age or older;

(b) Meet the education, experience, and competency qualifications specified under subsection (2)(e), (f), (g), (h), (i), and (j) of this section; and

(c) Discharge on-site program supervisory duties twenty hours or more a week.

(4) For the center serving the school age child only, the program supervisor may substitute equivalent courses in education, recreation, or physical education for required education.

(5) The director and program supervisor may be one and the same person when qualified for both positions. The director or program supervisor shall normally be on the premises while the child is in care. If temporarily absent from the center, the director and program supervisor shall leave a competent, designated staff person in charge who meets the qualifications of a lead staff person.

(6) The director and program supervisor may also serve as child care staff when such role does not interfere with the

director's or program supervisor's management and supervisory responsibilities.

(7) Center staffing. The licensee shall ensure the lead child care staff person in charge of a child or a group of children implementing the activity program:

(a) Is eighteen years of age or older; and

(b) Possesses a high school education or equivalent; or

(c) Has child development knowledge and experience;

(d) Has completed one of the following prior to or within the first six months of licensure or employment except as provided in subsection (7)(e) of this section:

(i) Twenty clock hours or two college quarter credits of basic training. Training shall be approved by the Washington state training and registry system (Washington STARS); or

(ii) Current child development associate (CDA) or equivalent credential or twelve or more college quarter credits in early childhood education or child development; or

(iii) Associate of arts (AA) or associate of applied science (AAS) or higher college degree in early childhood education or child development.

(e) Lead child care staff persons who are already employed on the effective date of this rule must complete the training required in WAC 388-150-180 (7)(d) prior to or within twelve months after the effective date of this rule.

(8) The licensee may assign a child care assistant or aide to support lead child care staff. The child care assistant or aide shall be sixteen years of age or older. The child care assistant or aide shall care for the child under the direct supervision of the lead child care staff person. The licensee shall ensure no person under eighteen years of age is assigned sole responsibility for a group of children. The assistant or aide, eighteen years of age or older, may care for a child or group of children without direct supervision by a superior for a brief period time.

(9) The licensee may arrange for a volunteer to support lead child care staff. The volunteer shall be sixteen years of age or older. The volunteer shall care for the child under the direct supervision of the lead child care staff person. The licensee may count the volunteer in the staff-to-child ratio when the volunteer meets staff qualification requirements.

(10) Support service personnel. The licensee shall provide or arrange for fulfillment of administrative, clerical, accounting, maintenance, transportation, and food service responsibilities so the child care staff is free to concentrate on program implementation.

(11) The licensee shall ensure completion of support service duties occurs in a manner allowing the center to maintain required staff-to-child ratios.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-150-180, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-180, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-180, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-180, filed 11/20/90, effective 12/21/90.]

WAC 388-150-190 Group size and staff-child ratios.

(1) In centers licensed for thirteen or more children, the licensee shall conduct group activities within the following group size and staff-to-child ratio requirements, according to the age of the children:

AGE OF CHILDREN	STAFF-CHILD RATIO	MAXIMUM GROUP SIZE
1 mo. through 11 mos. (infant)	1:4	8
12 mos. through 29 mos. (toddler)	1:7	14
30 mos. through 5 years (preschooler)	1:10	20
5 years and older (school-age child)	1:15	30

(2) In centers licensed for twelve or fewer children, the licensee may combine children of different age groups, provided the licensee:

(a) Maintains the staff-to-child ratio designated for the youngest child in the mixed group; and

(b) Provides a separate care area when four or more infants are in care. In such case the maximum group size shall be eight children.

(3) The licensee shall conduct activities for each group in a specific room or other defined space within a larger area.

(4) The licensee shall ensure each group is under the direct supervision of a qualified staff person or team of staff involved in directing the child's activities.

(5) The department may approve reasonable variations to group size limitations if the licensee maintains required staff-to-child ratios, dependent on:

- (a) Staff qualifications;
- (b) Program structure; and
- (c) Usable square footage.

(6) After consulting with the child's parent, the licensee may place the individual child in a different age group and serve the child within the different age group's required staff-to-child ratio based on the child's:

- (a) Developmental level; and
- (b) Individual needs.

(7) The licensee may briefly combine children of different age groups provided the licensee maintains the staff-to-child ratio and group size designated for the youngest child in the mixed group.

(8) In centers licensed for thirteen or more children, the licensee may group ambulatory children between one year, and two and one-half years of age with older children, provided:

(a) The total number of children in the group does not exceed twelve; and

- (b) Two staff are assigned to the group.

(9) The licensee shall ensure the staff person providing direct care and supervision of the child is free of other duties at the time of care.

(10) The licensee shall maintain required staff-to-child ratios indoors, outdoors, on field trips, and during rest periods. During rest periods, staff may be involved in other activities if staff remain on the premises and each child is within continuous visual and auditory range of a staff person.

(11) The licensee shall ensure staff:

- (a) Attend the child or group of children at all times; and
- (b) Keep each child within continuous visual and auditory range, except when a toilet-trained child uses the toilet.

(12) When only one staff person is present, the licensee shall ensure a second staff person is readily available in case of an emergency.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-190, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-200, filed 11/20/90, effective 12/21/90.]

(1999 Ed.)

RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-190, filed 11/20/90, effective 12/21/90.]

WAC 388-150-200 Staff development and training.

(1) The licensee shall have an orientation system making the employee and volunteer aware of program policies and practices. The licensee shall provide staff an orientation including, but not limited to:

- (a) Minimum licensing rules required under this chapter;
- (b) Goals and philosophy of the center;
- (c) Planned daily activities and routines;
- (d) Child guidance and behavior management methods;
- (e) Child abuse and neglect prevention, detection, and reporting policies and procedures;
- (f) Special health and developmental needs of the individual child;
- (g) The health care plan;
- (h) Fire prevention and safety procedures;
- (i) Personnel policies, when applicable;
- (j) Limited restraint techniques;
- (k) Cultural relevancy; and
- (l) Developmentally appropriate practices.

(2) The licensee shall provide or arrange for regular training opportunities for the child care staff to promote ongoing employee education and enhance practice skills.

(3) The licensee shall conduct periodic staff meetings for planning and coordination purposes.

(4) The licensee shall ensure:

(a) A staff person with basic, standard, current first aid and cardiopulmonary resuscitation (CPR) training, or department of health approved training, is present at all times and in all areas the child is in care; and

(b) Staff's CPR training includes methods appropriate for child age groups in care.

(5) The licensee shall provide or arrange appropriate education and training for child care staff on the prevention and transmission of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

(6) The licensee shall ensure the staff person preparing full meals has a valid food handler permit.

(7) The licensee shall ensure that the director, program supervisor and lead staff annually, beginning one year after licensure or employment, complete ten clock hours or one college quarter credit of training approved by the Washington state training and registry system (STARS). For those already employed or licensed on the effective date of this rule, this requirement for annual training shall begin one year after the effective date of this rule.

For the director and the program supervisor, five of the ten hours of training shall be in program management and administration.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-150-200, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-200, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-200, filed 11/20/90, effective 12/21/90.]

WAC 388-150-210 Health care plan. (1) The licensee shall maintain current written health policies and procedures for staff orientation and use, and for the parent. The health

care plan shall include, but not be limited to, information about the center's procedures concerning:

(a) Communicable disease prevention, reporting, and management;

(b) Action taken for medical emergencies;

(c) First aid;

(d) Care of minor illnesses;

(e) Medication management;

(f) General hygiene practices;

(g) Handwashing practices;

(h) Food and food services; and

(i) Infant care procedures and nursing consultation, where applicable.

(2) In centers licensed for thirteen or more children, the licensee shall use the services of an advisory physician, physician's assistant, or registered nurse to assist in the development, approval, and periodic review of the center's health care plan. This medical practitioner shall sign and date the health plan.

[Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-210, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 91-07-013 (Order 3151), § 388-150-210, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-210, filed 11/20/90, effective 12/21/90.]

WAC 388-150-220 Health supervision and infectious disease prevention. (1) Child. The licensee shall encourage the parent to arrange a physical examination for the child who has not had regular health care or a physical examination within one year before enrollment.

(2) The licensee shall encourage the parent to obtain health care for the child when necessary. The licensee shall not be responsible for providing or paying for the child's health care.

(3) Before or on the child's first day of attendance, the licensee shall have on file a certificate of immunization status form prescribed by the department of health proving the child's full immunization for:

(a) Diphtheria;

(b) Tetanus;

(c) Pertussis (whooping cough);

(d) Poliomyelitis;

(e) Measles (rubeola);

(f) Rubella (German measles);

(g) Mumps; and

(h) Other diseases prescribed by the department of health.

(4) The licensee may accept the child without all required immunizations on a conditional basis if immunizations are:

(a) Initiated before or on enrollment; and

(b) Completed as rapidly as medically possible.

(5) The licensee may exempt the immunization requirement for the child if the parent or guardian:

(a) Signs a statement expressing a religious, philosophical, or personal objection; or

(b) Furnishes a physician's statement of a valid medical reason for the exemption.

(6) Program. Staff shall daily observe and screen the child for signs of illness. The licensee shall care for or dis-

charge home the ill child based on the center's policies concerning the ill child.

(a) When the child has a severe illness or is injured, tired, or upset, staff shall separate the child from other children and attend the child continuously until:

(i) The child is able to rejoin the group;

(ii) Staff return the child to the parent; or

(iii) Staff secure appropriate health care for the child.

(b) The licensee shall provide a quiet, separate care room or area allowing the child requiring separate care an opportunity to rest.

(c) Staff shall sanitize equipment used by the child if staff suspects the child has a communicable disease.

(d) The licensee may use the separate care room or area for other purposes when not needed for separation of the child.

(7) Staff shall wash, or assist the child to wash hands:

(a) After the child's toileting or diapering;

(b) Before the child eats; and

(c) Before the child participates in food activities.

(8) Staff shall clean and disinfect toys, equipment, furnishings, and facilities according to the center's cleaning and disinfecting policies, as needed.

(9) The licensee shall have appropriate extra clothing available for the child who wets or soils clothes.

(10) Staff shall ensure the child does not share personal hygiene or grooming items.

(11) Staff. Each center employee, volunteer, and other person having regular contact with the child in care shall have a tuberculin (TB) skin test, by the Mantoux method, upon employment or licensure, unless against medical advice.

(a) The person whose TB skin test is positive (ten millimeters or more induration) shall have a chest x-ray within thirty days following the skin test.

(b) The licensee shall not require the person to obtain routine periodic TB retesting or x-ray (biennial or otherwise) after entry testing unless directed to obtain retesting by the person's health care provider or the local health department.

(12) The licensee shall not permit the person with a reportable communicable disease to be on duty in the center or have contact with the child in care unless approved in writing by a health care provider.

(13) Staff shall wash hands:

(a) After toileting and diapering the child;

(b) After personal toileting;

(c) After attending to an ill child; and

(d) Before serving or preparing food.

[Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-220, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-220, filed 11/20/90, effective 12/21/90.]

WAC 388-150-230 Medication management. The center may have a policy of not giving medication to the child in care. If the center's health care plan includes giving medication to the child in care, the licensee:

(1) Shall give medications, prescription and nonprescription, only on the written approval of a parent, person, or agency having authority by court order to approve medical care;

(2) Shall give prescription medications:

- (a) Only as specified on the prescription label; or
- (b) As authorized, in writing, by a physician or other person legally authorized to prescribe medication.

(3) Shall give the following classifications of nonprescription medications, with written parent authorization, only at the dose, duration, and method of administration specified on the manufacturer's label for the age or weight of the child needing the medication:

- (a) Antihistamines;
- (b) Nonaspirin fever reducers/pain relievers;
- (c) Nonnarcotic cough suppressants;
- (d) Decongestants;
- (e) Anti-itching ointments or lotions, intended specifically to relieve itching;
- (f) Diaper ointments and powders, intended specifically for use in the diaper area of the child; and
- (g) Sun screen.

(4) Shall give other nonprescription medication:

- (a) Not included in the categories listed in subsection (3) of this section; or
- (b) Taken differently than indicated on the manufacturer's label; or
- (c) Lacking labeled instructions, only when disbursement of the nonprescription medication is as required under subsection (4)(a), (b), and (c):
- (i) Authorized, in writing, by a physician; or
- (ii) Based on established medical policy approved, in writing, by a physician or other person legally authorized to prescribe medication.

(5) Shall accept from the child's parent, guardian, or responsible relative only medicine in the original container, labeled with:

- (a) The child's first and last names;
- (b) The date the prescription was filled; or
- (c) The medication's expiration date; and
- (d) Legible instructions for administration, such as manufacturer's instructions or prescription label.

(6) Shall keep medication, refrigerated or nonrefrigerated, in an orderly fashion, inaccessible to the child;

(7) Shall store external medication in a compartment separate from internal medication;

(8) Shall keep a record of medication disbursed;

(9) Shall return to the parent or other responsible party, or shall dispose of medications no longer being taken; and

(10) May, at the licensee's option, permit self-administration of medication by a child in care if the:

- (a) Child is physically and mentally capable of properly taking medication without assistance;
- (b) Licensee includes in the child's file a parental or physician's written statement of the child's capacity to take medication without assistance; and
- (c) Licensee ensures the child's medications and other medical supplies are stored so the medications and medical supplies are inaccessible to another child in care.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-230, filed 11/20/90, effective 12/21/90.]

(1999 Ed.)

WAC 388-150-240 Nutrition. (1) The licensee shall provide food meeting the nutritional needs of the child in care, taking into consideration the:

- (a) Number of children in care;
- (b) Child's age and developmental level;
- (c) Child's cultural background;
- (d) Child's handicapping condition; and
- (e) Hours of care on the premises.

(2) The licensee shall provide only pasteurized milk or a pasteurized milk product.

(3) The licensee shall provide only whole milk to the child twenty-three months of age or younger except with written permission of the child's parent.

(4) The licensee may serve the child twenty-four months of age or older powdered Grade A milk mixed in the center provided the licensee completes the dry milk mixture, service, and storage in a safe and sanitary manner.

(5) The licensee may provide the child nutrient concentrates, nutrient supplements, a modified diet, or an allergy diet only with written permission of the child's health care provider. The licensee shall obtain from the parent or child's health care provider a written list of foods the child cannot consume.

(6) The licensee shall:

- (a) Record food and portion sizes planned and served;
- (b) Prepare and date menus one week or more in advance, containing meals and snacks to be served, including parent-provided snacks; and
- (c) Specify on the menu a variety of foods enabling the child to consume adequate nutrients.

(7) The licensee shall provide two weeks or more of meal and snack menu variety before repeating the menu.

(8) The licensee shall only make nutrition substitutions of comparable nutrient value and record changes on the menu.

(9) The licensee shall use the following meal pattern to provide food to the child in care in age-appropriate servings:

- (a) Providing the child in care for nine or less hours:
 - (i) Two or more snacks and one meal; or
 - (ii) Two meals and one snack.
- (b) Providing the child in care for nine or more hours:
 - (i) Two or more meals and two snacks; or
 - (ii) One meal and three snacks.
- (c) Providing the child arriving after school a snack;
- (d) Providing the child food at intervals not less than two hours and not more than three and one-half hours apart; and
- (e) Allowing the occasional serving of party foods not meeting nutritional requirements.

(10) When serving food, the licensee shall provide the child the following:

- (a) At a minimum, the child's breakfast must contain:
 - (i) A dairy product, including fluid milk, cheese, yogurt, or cottage cheese;
 - (ii) Cereal or bread, whole grain or enriched; and
 - (iii) Fruit or vegetable or juice containing a minimum of fifty percent real juice.
- (b) At a minimum, the child's lunch or dinner must contain:
 - (i) A dairy product;

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- (ii) A protein food including lean meat, fish, poultry, egg, legumes, nut butters, or cheese;
- (iii) Bread or bread alternate, whole grain or enriched; and
- (iv) Fruit or vegetable, two total servings.
- (c) In centers not serving full meals, the child's snacks must include one or more dairy or protein source provided daily, and contain a minimum of two of the following four components at each snack:
 - (i) A dairy product;
 - (ii) A protein food;
 - (iii) Bread or bread alternate; or
 - (iv) Fruit or vegetable or juice containing a minimum of fifty percent real juice.
- (d) The child's food must contain:
 - (i) A minimum of one serving of Vitamin C fruit, vegetable, or juice, provided daily; and
 - (ii) Servings of food high in Vitamin A, provided three or more times weekly.
- (11) The licensee shall provide:
 - (a) Dinner to the child in evening care when the child did not receive dinner at home before arriving at the center;
 - (b) A bedtime snack to the child in nighttime care; and
 - (c) Breakfast to the child in nighttime care if the child remains at the center after the child's usual breakfast time.
- (12) The licensee shall monitor sack lunches, snacks, and other foods brought from the child's home for consumption by the child, all children, or a group of children in care, ensuring safe preparation, storage, and serving and nutritional adequacy.
- (13) For the center permitting sack lunches, the licensee shall have available food supplies to supplement food deficient in meeting nutrition requirements brought from the child's home and to nourish the child arriving without home-supplied food.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-240, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-240, filed 11/20/90, effective 12/21/90.]

WAC 388-150-250 Kitchen and food service. (1) The licensee shall provide equipment for the proper storage, preparation, and service of food to meet program needs.

- (2) The licensee shall meet food service standards by requiring:
 - (a) The staff person preparing full meals have a valid food handler permit;
 - (b) The staff person preparing and serving meals wash hands before handling food;
 - (c) Handwashing facilities be located in or adjacent to food preparation areas;
 - (d) Food be stored in a sanitary manner, especially milk, shellfish, meat, poultry, eggs, and other protein food sources;
 - (e) Food requiring refrigeration be stored at a temperature no warmer than forty-five degrees Fahrenheit;
 - (f) Frozen food be stored at a maximum temperature of zero degrees Fahrenheit;
 - (g) Refrigerators and freezers be equipped with thermometers and be regularly cleaned and defrosted;
 - (h) Food be cooked to correct temperatures;
- (i) Raw food be washed thoroughly with clean running water;
- (j) Cooked food to be stored be rapidly cooled and refrigerated after preparation;
- (k) Food be kept in original containers or in clean, labeled containers and stored off the floor;
- (l) Packaged, canned, and bottled food with a past expiration date be discarded;
- (m) Food in dented cans or torn packages be discarded; and
- (n) When food containing sulfiting agents is served, parents be notified.

- (3) The child may participate in food preparation as an education activity. The licensee shall supervise the child when the child is in the kitchen or food preparation area.
- (4) The licensee shall make kitchen equipment inaccessible to the child, except during planned and supervised kitchen activities. Staff shall supervise food preparation activities. The licensee shall make potentially hazardous appliances and sharp or pointed utensils inaccessible to the child when the child is not under direct supervision.
- (5) The licensee shall install and maintain kitchen equipment and clean re-usable utensils in a safe and sanitary manner.
- (6) The licensee shall sanitize reusable utensils in a dishwasher or through use of a three-compartment dishwashing procedure.
- (7) The licensee shall use only single-use or clean cloths, used solely for wiping food service, preparation, and eating surfaces.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-250, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-250, filed 11/20/90, effective 12/21/90.]

WAC 388-150-260 Drinking and eating equipment. (1) The licensee shall provide the child disposable single-use cups, individual drinking cups or glasses, or inclined jet-type drinking fountains.

- (2) The department shall prohibit the center from using bubbler-type drinking fountains and common drinking cups or glasses.
- (3) The licensee shall provide the child durable eating utensils appropriate in size and shape for the child in care.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-260, filed 11/20/90, effective 12/21/90.]

WAC 388-150-270 Care of young children. (1) The licensee shall not accept for care a child under one month of age.

- (2) Facility. The licensee shall:
 - (a) Provide a separate, safe play area for the child under one year of age, or the child not walking;
 - (b) In centers licensed for thirteen or more children, care for the child under one year of age in rooms or areas separate from older children, with:
 - (i) Not more than eight children under one year of age to a room or area; and
 - (ii) Handwashing facilities in or adjacent to each such room or area.

(3) Diapering and toileting. The licensee shall ensure:

- (a) The diaper changing area is:
 - (i) Separate from food preparation areas;
 - (ii) Adjacent to a handwashing sink; and
 - (iii) Sanitized between use for different children; or
 - (iv) Protected by a disposable covering discarded after each use.
- (b) The designated change area is impervious to moisture and washable;
- (c) Diaper changing procedures are posted at the changing area;
- (d) Disposable towels or clean, reusable towels, laundered between usage for different children, are used for cleaning the child;
- (e) Staff wash hands after diapering the child or helping the child with toileting;
- (f) Disposable diapers, a commercial diaper service, or reusable diapers supplied by the child's family are used;
- (g) Soiled diapers are placed without rinsing into a separate, cleanable, covered container provided with a waterproof liner before transporting to the laundry, parent, or acceptable disposal;
- (h) Soiled diapers are removed from the facility daily or more often unless the licensee uses a commercial diaper service;
- (i) Toilet training is initiated when the child indicates readiness and in consultation with the child's parent;
- (j) Potty chairs, when in use, are located on washable, impervious surfaces; and
- (k) Toilet training equipment is sanitized after each use.

(4) Feeding. The licensee and the infant's parent shall agree on a schedule for the infant's feedings.

- (a) Bottle feedings.
- (i) The licensee or parent may provide the child's bottle feeding in the following manner:
 - (A) A filled bottle brought from home;
 - (B) Whole milk or formula in ready-to-feed strength; or
 - (C) Formula requiring no preparation other than dilution with water, mixed on the premises.
- (ii) The licensee shall prepare the child's bottle and nipple in a sanitary manner in an area separate from diapering areas.
- (iii) The licensee shall sanitize the child's bottle and nipple between uses.
- (iv) The licensee shall label the child's bottle with the child's name and date prepared.
- (v) The licensee shall refrigerate a filled bottle if the child does not consume the content immediately and shall discard the bottle's content if the child does not consume the content within twelve hours.
- (b) To ensure safety and promote nurturing, the licensee shall ensure staff:
 - (i) Hold in a semi-sitting position for feedings the infant unable to sit in a high chair, unless such is against medical advice;
 - (ii) Interact with the child;
 - (iii) Do not prop a bottle;
 - (iv) Do not give a bottle to the reclining child, unless the bottle contains water only;

- (v) Take the bottle from the child when the child finishes feeding; and
- (vi) Keep the child in continuous visual and auditory range.

(c) The licensee shall provide semi-solid food for the infant, upon consultation with the parent, not before the child is four months of age and not later than ten months of age, unless such is not recommended by the child's health care provider.

(5) Sleeping equipment. The licensee shall furnish the infant a single-level crib, infant bed, bassinet, or play pen for napping until such time the licensee and parent concur the infant can safely use a mat, cot, or other approved sleeping equipment.

(6) When the licensee furnishes the infant or child a crib, the licensee shall ensure the crib is:

- (a) Sturdy and made of wood, metal, or plastic with secure latching devices; and
- (b) Constructed with two and three-eighths inches or less space between vertical slats when the crib is used for an infant six months of age or younger. The licensee may allow an infant to use a crib not meeting the spacing requirement provided the licensee uses crib bumpers or another effective method preventing the infant's body from slipping between the slats.

(7) The licensee shall not allow the infant or child to use a stacked crib.

(8) The licensee shall ensure the infant's or child's crib mattress is:

- (a) Snug fitting, preventing the infant from being caught between the mattress and crib side rails; and
- (b) Waterproof and easily sanitized.

(9) Program and equipment. The licensee shall provide the infant a daily opportunity for:

- (a) Large and small muscle development;
- (b) Crawling and exploring;
- (c) Sensory stimulation;
- (d) Social interaction;
- (e) Development of communication; and
- (f) Learning self-help skills.

(10) The licensee shall provide the infant safe, non-ingestible, and suitable toys and equipment for the infant's mental and physical development.

(11) Nursing consultation. The licensee licensed for the care of four or more infants shall arrange for regular nursing consultation to include one or more monthly on-site visits by a registered nurse trained or experienced in the care of young children.

(12) In collaboration with the licensee, the nurse shall advise the center on the:

- (a) Operation of the infant care program; and
- (b) Implementation of the child health program.

(13) The licensee shall obtain a written agreement with the nurse for consultation services.

(14) The licensee shall document the nurse's on-site consultations.

(15) The licensee shall ensure the nurse consultant's name and telephone number is posted or otherwise available on the premises.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-270, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-270, filed 11/20/90, effective 12/21/90.]

WAC 388-150-280 General safety, maintenance, and site. (1) The licensee shall operate the center:

- (a) On an environmentally safe site;
- (b) In a neighborhood free from a condition detrimental to the child's welfare; and
- (c) In a location accessible to other services to carry out the program.

(2) The licensee shall maintain the indoor and outdoor premises in a safe and sanitary condition, free of hazards, and in good repair. The licensee shall ensure furniture and equipment are safe, stable, durable, child-sized, and free of sharp, loose, or pointed parts.

(3) The licensee shall:

- (a) Install handrails or safety devices at child height adjacent to steps, stairways, and ramps;
- (b) Maintain a flashlight or other emergency lighting device in working condition;
- (c) Ensure there is no flaking or deteriorating lead-based paint on interior and exterior surfaces, equipment, and toys accessible to the preschool age and younger child;
- (d) Finish or cover rough or untreated wood surfaces; and
- (e) Maintain one or more telephones on the premises in working order, accessible to staff.

(4) The licensee shall supply bathrooms and other rooms subject to moisture with washable, moisture-impervious flooring.

(5) The licensee caring for the preschool age and younger child shall equip child-accessible electrical outlets with nonremovable safety devices or covers preventing electrical injury.

(6) The licensee shall ensure staff can gain rapid access in an emergency to a bathroom or other room occupied by the child.

(7) The licensee shall shield light bulbs and tubes in child-accessible areas.

(8) The licensee shall keep the premises free from rodents, fleas, cockroaches, and other insects and pests.

(9) The licensee shall use a housekeeping sink or another appropriate method for drawing clean mop water and disposing waste water.

(10) The licensee shall ensure the mop storage area is ventilated.

(11) The licensee shall ensure no firearm or another weapon is on the premises.

(12) The licensee shall comply with fire safety regulations adopted by the state fire marshal's office.

(13) The licensee shall ensure that rooms or closets to be made inaccessible to children shall be equipped with a lock or approved safety latch.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-280, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-280, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-280, filed 11/20/90, effective 12/21/90.]

WAC 388-150-290 Water safety. (1) The licensee shall maintain the following water safety precautions when the child uses an on-premises swimming pool, wading pool, or natural body of water, or enters the water on a field trip by ensuring:

- (a) The on-premises pool or natural body of water is inaccessible to the child when not in use;
- (b) During the child's use of a wading pool, an adult with current CPR training supervises the child at all times; and
- (c) During the child's use of a swimming pool or open body of water, a certified lifeguard is present at all times, in addition to required staff.

(2) The licensee shall daily empty and clean portable wading pools when in use.

(3) The licensee shall not permit the child to use or access a hot tub, spa, whirlpool, tank, or similar equipment.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-290, filed 11/20/90, effective 12/21/90.]

WAC 388-150-295 Water supply, sewage, and liquid wastes. (1) The licensee shall obtain approval of a private water supply by the local health authority or department.

(2) The licensee shall ensure sewage and liquid wastes are discharged into:

- (a) A public sewer system; or
- (b) An independent sewage system approved by the local health authority or department.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-295, filed 8/18/93, effective 9/18/93.]

WAC 388-150-310 First-aid supplies. The licensee shall maintain on the premises adequate first-aid supplies, conforming with the center's first-aid policies and procedures. The licensee's first-aid supplies shall include unexpired syrup of ipecac which may be administered only on the advice of a physician or poison control center.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-310, filed 11/20/90, effective 12/21/90.]

WAC 388-150-320 Outdoor play area. (1) The licensee shall provide a safe and securely-fenced or department-approved, enclosed outdoor play area:

- (a) Adjoining directly the indoor premises; or
- (b) Reachable by a safe route and method; and
- (c) Promoting the child's active play, physical development, and coordination; and
- (d) Protecting the play area from unsupervised exit or entry by the child; and
- (e) Preventing child access to roadways and other dangers.

(2) The licensee shall ensure the play area contains a minimum of seventy-five usable square feet per child. If the center uses a rotational schedule of outdoor play periods so only a portion of the child population uses the play area at one time, the licensee may reduce correspondingly the child's play area size. The licensee shall ensure appropriate child grouping by developmental or age levels, staff-to-child ratio adherence, and group size maintenance.

(3) At its discretion, the department may approve the licensee providing drop-in care only or operating in a densely

developed area to use equivalent, separate, indoor space for the child's large muscle play.

(4) The licensee providing full-time care shall ensure the center's activity schedule affords the child sufficient daily time to participate actively in outdoor play.

(5) The licensee shall provide a variety of age appropriate play equipment for climbing, pulling, pushing, riding, and balancing activities. The licensee shall arrange, design, construct, and maintain equipment and ground cover to prevent child injury. The licensee's quantity of outdoor play equipment shall offer the child a range of outdoor play options.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-320, filed 11/20/90, effective 12/21/90.]

WAC 388-150-330 Indoor play area. (1) The center's indoor premises shall contain adequate area for child play and sufficient space to house a developmentally appropriate program for the number and age range of children served. The licensee shall provide a minimum of thirty-five square feet of usable floor space per child, exclusive of a bathroom, hallway, and closet. If the staff removes mats and cots when not in use, the licensee may use and consider the napping area as child care space.

(2)(a) The licensee may consider the kitchen usable space if:

- (i) Appliances and utensils do not create a safety hazard;
- (ii) Toxic or harmful substances are not accessible to the child;
- (iii) Food preparation and storage sanitation is maintained; and
- (iv) The space is located safely and appropriately for use as a child care activity area.

(b) The department may allow the licensee the use of a kitchen for occasional activities, but not include the kitchen in calculating the center's capacity.

(c) The department may allow the licensee to count the kitchen in calculating the center's capacity if the kitchen is:

- (i) Adjacent to the care area;
- (ii) Available for more than an occasional activity; and
- (iii) Large enough for group activities.

(3) The licensee shall provide a minimum of fifty square feet of usable floor space per child for the play and napping of the infant and other child requiring a crib.

(4) The licensee may use a room for multiple purposes such as playing, dining, napping, and learning activities, provided the:

- (a) Room is of sufficient size; and
- (b) Room's usage for one purpose does not interfere with usage of the room for another purpose.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-330, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-330, filed 11/20/90, effective 12/21/90.]

WAC 388-150-340 Toilets, handwashing sinks, and bathing facilities. (1) The licensee shall provide a minimum of one indoor flush-type toilet and one adjacent handwash sink for every fifteen children normally on site, except:

(a) The child eighteen months of age or younger and other children using toilet training equipment need not be

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included when determining the number of required flush-type toilets;

(b) If urinals are provided, the number of urinals shall not replace more than one-third of the total required toilets; and

(c) For the center serving the school age child only, the number of sinks and toilets for the child shall equal or exceed the number required by the local school district.

(2) The licensee shall supply the child warm running water for handwashing at a temperature range not less than eighty-five degrees Fahrenheit and not more than one hundred and twenty degrees Fahrenheit.

(3) The licensee shall locate the child's handwashing facilities in or adjacent to rooms used for toileting.

(4) The licensee shall provide toileting privacy for the child of opposite sex six years of age and older and for other children demonstrating a need for privacy.

(5) The licensee shall provide toilets, urinals, and handwashing sinks of appropriate height and size for the child in care or furnish safe, easily cleanable platforms impervious to moisture.

(6) The licensee shall provide a mounted toilet paper dispenser for each toilet.

(7) The licensee shall ensure rooms used for toileting are ventilated to the outdoors.

(8) When the center serves the child not toilet trained, the licensee shall provide developmentally appropriate equipment for the toileting and toilet training of the young child. The licensee shall sanitize the equipment after each child's use.

(9) The licensee shall provide the child with soap and individual towels or other appropriate devices for washing and drying the child's hands and face.

(10) If the center is equipped with a bathing facility, the licensee shall:

- (a) Make the bathing facility inaccessible to the child; or
- (b) Ensure the preschool age and younger child is supervised while using the bathing facility; and
- (c) Equip the bathing facility with a conveniently located grab bar or other safety device such as a nonskid pad.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-340, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-340, filed 11/20/90, effective 12/21/90.]

WAC 388-150-350 Laundry. (1) The licensee shall maintain access to laundry washing and drying facilities, which may include using on-premises or off-site equipment.

(2) The licensee shall use an effective method through temperature or chemical measures for adequately sanitizing the child's laundry contaminated with urine, feces, lice, scabies, or other infectious material.

(3) When washing or drying occurs on-site, the licensee shall locate equipment in an area separate from the kitchen and inaccessible to the child.

(4) The licensee shall store the child's soiled laundry separately from clean laundry.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-350, filed 11/20/90, effective 12/21/90.]

WAC 388-150-360 Nap and sleep equipment. (1) The licensee shall provide a clean, separate, firm mat, cot, bed, mattress, play pen, or crib for each child five years of age and under remaining in care for six or more hours and for another child requiring a nap or rest period.

(2) The licensee shall ensure the child's mat is of sufficient length, width, and thickness to provide adequate comfort for the child to nap. The licensee may use a washable sleeping bag meeting the mat requirements for the toilet-trained child.

(3) The licensee shall ensure the child's cot is of sufficient length and width and constructed to provide adequate comfort for the child to nap. The licensee shall ensure the cot surface is of a material which can be cleaned with a detergent solution, disinfected, and allowed to air dry.

(4) The licensee shall clean the child's nap equipment as needed and between use by another child.

(5) The licensee shall separate the child's nap equipment when in use to facilitate sanitation, child comfort, and staff access.

(6) The licensee shall ensure the child's bedding:

(a) Consists of a clean sheet or blanket to cover the sleeping surface and a clean, suitable cover for the child;

(b) Is laundered weekly or more often and between use by different children; and

(c) Is stored separately from bedding used by another child.

(7) The licensee shall not use the upper bunk of a double deck bed for a preschool age or younger child.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-360, filed 11/20/90, effective 12/21/90.]

WAC 388-150-370 Storage. (1) The licensee shall provide accessible individual space for the child to store clothes and personal possessions.

(2) The licensee shall provide space separate from child care area to store play and teaching equipment and supplies, records and files, cots, mats, and bedding.

(3) The licensee shall store and make inaccessible to the child cleaning supplies, toxic substances, paint, poisons, aerosol containers, and items bearing warning labels.

(4) The licensee shall label a container filled from a stock supply to identify contents.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-370, filed 11/20/90, effective 12/21/90.]

WAC 388-150-380 Program atmosphere. (1) The licensee shall provide a cheerful learning environment for the child by:

(a) Covering walls and ceilings with light or bright colors; and

(b) Placing visually stimulating decorations, pictures, or other attractive materials at appropriate heights for the child.

(2) The licensee shall maintain a safe and developmentally appropriate noise level, without inhibiting normal ranges of expression by the child, so staff and child can be clearly heard and understood in normal conversation.

(3) The licensee shall locate light fixtures and provide lighting intensities promoting good visibility and comfort for the child care.

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(4) The licensee shall maintain the temperature within the center at:

(a) Sixty-eight degrees Fahrenheit or more during the child's waking hours; and

(b) Sixty degrees Fahrenheit or more during the child's napping or sleeping hours.

(5) The licensee shall regulate the temperature and ventilate the center for the health and comfort of the child in care.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-380, filed 11/20/90, effective 12/21/90.]

WAC 388-150-390 Discrimination prohibited. (1) Child day care centers are defined by state and federal law as places of public accommodation and shall not discriminate in employment practices and client services on the basis of race, creed, color, national origin, sex, age, or disability.

(2) Day care centers shall:

(a) Post a nondiscrimination poster;

(b) Have a nondiscrimination plan;

(c) Have a nondiscrimination policy; and

(d) Comply with the requirements of the Americans with Disabilities Act in respect to accessibility.

[Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-390, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-390, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-390, filed 11/20/90, effective 12/21/90.]

WAC 388-150-400 Religious activities. (1) Consistent with state and federal laws, the licensee shall respect and facilitate the rights of the child in care to observe the tenets of the child's faith.

(2) The licensee shall not punish or discourage the child for exercising these rights.

(3) If the center conducts a religious activity program, the licensee shall maintain a written description of the center's religious policies and practices affecting the child in care.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-400, filed 11/20/90, effective 12/21/90.]

WAC 388-150-410 Special requirements regarding American Indian children. When five percent or more of the center's child enrollment consists of Indian children, the licensee shall develop social service resources and staff training programs designed to meet the special needs of such children through coordination with tribal, Indian health service, and Bureau of Indian Affairs social service staff, and appropriate urban Indian and Alaskan native consultants.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-410, filed 11/20/90, effective 12/21/90.]

WAC 388-150-420 Child abuse, neglect, and exploitation. The licensee and staff shall protect the child in care from child abuse, neglect, or exploitation, as required under chapter 26.44 RCW.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-420, filed 11/20/90, effective 12/21/90.]

WAC 388-150-430 Prohibited substances. (1) During operating hours or when the child is in care, the licensee, staff, and volunteers on center premises or caring for the child off-site shall not be under the influence of, consume, or possess an:

- (a) Alcoholic beverage; or
- (b) Illegal drug.

(2) The licensee shall prohibit smoking in the center when the child is present and in a motor vehicle when the licensee transports the child. The licensee may permit on premises smoking out doors, away from the building, where the child is not present.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-430, filed 11/20/90, effective 12/21/90.]

WAC 388-150-440 Limitations to persons on premises. (1) During center operating hours or while the child is in care, only the licensee, employee, or volunteer, or an authorized representative of a governmental agency, or parent shall have unsupervised or regular access to the child in care.

(2) The licensee shall allow the parent of the child in care unsupervised access only to the parent's child.

[Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-440, filed 11/20/90, effective 12/21/90.]

WAC 388-150-450 Child records and information. The licensee shall maintain on the premises organized confidential records and information concerning the child in care. The licensee shall ensure the child's record contains, at a minimum:

(1) Registration data:

- (a) Name, birthdate, dates of enrollment and termination, and other identifying information;
- (b) Name, address, and home and business telephone number of the parent and other person to be contacted in case of emergency; and
- (c) Completed enrollment application signed by the parent, guardian, or responsible relative.

(2) Authorizations:

- (a) Name, address, and telephone number of the person authorized to remove from the center the child under care;
- (b) Written parental consent for transportation provided by the center, including field trips and swimming, when the child participates in these activities. A parent-signed blanket consent form may authorize the child's off-site travel; and
- (c) Written parental consent, or court order, for providing medical care and emergency surgery, except for such care authorized by law.

(3) Medical and health data:

- (a) Date and kind of illness and injury occurring on the premises, including the treatment given by staff;
- (b) Medication given indicating dosage, date, time, and name of dispensing staff person; and
- (c) A health history, obtained when the licensee or staff enrolls the child for care. The history includes:
 - (i) The date of the child's last physical examination;
 - (ii) Allergies;
 - (iii) Special health or developmental problems and other pertinent health information;

(iv) Immunization history as required under WAC 388-150-220; and

(v) Name, address, and telephone number of the child's health care provider or facility.

[Statutory Authority: RCW 74.15.030. 91-07-013 (Order 3151), § 388-150-450, filed 3/12/91, effective 4/12/91; 90-23-078 (Order 3103), § 388-150-450, filed 11/20/90, effective 12/21/90.]

WAC 388-150-460 Program records. The licensee shall maintain the following documentation on the premises:

(1) The daily attendance record:

(a) The parent, or other person authorized by the parent to take the child to or from the center, shall sign in the child on arrival and shall sign out the child at departure, using a full, legal signature; and

(b) When the child leaves the center to attend school or participate in off-site activities as authorized by the parent, the staff person shall sign out the child, and sign in the child on return to the center.

(2) A copy of the report sent to the licensor about the illness or injury to the child in care requiring medical treatment or hospitalization;

(3) Copies of meal and snack menus for a minimum of six months;

(4) The twelve-month record indicating the date and time the licensee conducted the required monthly fire evacuation drills;

(5) A written plan for staff development specifying the content, frequency, and manner of planned training;

(6) Activity program plan records;

(7) Nursing consultation records, if applicable, including:

(a) A copy of the written agreement with the nurse; and

(b) A summary of the nurse's on-site consultation activities.

(8) A record of:

(a) Accidents;

(b) Injuries; and

(c) Incidents requiring restraint.

(9) Attendance records and invoices for state-paid children for at least five years.

[Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-150-460, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.020 and 74.15.030. 93-18-001 (Order 3623), § 388-150-460, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030. 90-23-078 (Order 3103), § 388-150-460, filed 11/20/90, effective 12/21/90.]

WAC 388-150-470 Personnel policies and records.

(1) Each employee and volunteer having unsupervised or regular access to the child in care shall complete and submit to the licensee or director by the date of hire:

(a) An application for employment on a department-prescribed form, or its equivalent; and

(b) A criminal history and background inquiry form.

(i) The licensee shall submit this form to the department for the employee and volunteer, within seven calendar days of the employee's first day of employment, permitting a criminal and background history check.

(ii) The department shall discuss the inquiry information with the licensee or director, when applicable.

(2) Each employee serving as a director, program supervisor, or lead child care staff person shall complete and submit to the licensee or director by the date of hire a Washington state training and registry system (STARS) profile form. The licensee shall submit this form to the Washington state training and registry system within seven calendar days of the employee's first day of employment, to permit the department to track the employee's compliance with training requirements.

(3) The licensee employing five or more persons shall have written personnel policies describing staff benefits, if any, duties, and qualifications.

(4) The licensee shall maintain a personnel recordkeeping system, having on file, on the premises, for the licensee, staff person, and volunteer:

(a) An employment application, including work and education history;

(b) Documentation of criminal history and background inquiry form submission;

(c) A record of tuberculin skin test results, x-ray, or an exemption to the skin test or x-ray;

(d) Documentation of HIV/AIDS education and training;

(e) A record of participation in staff development training;

(f) Documentation of orientation program completion;

(g) Documentation of a valid food handler permit, when applicable;

(h) Documentation of current first aid and CPR training, when applicable; and

(i) Documentation of basic and annual training required under WAC 388-150-180 (2)(i) or (7)(b) and 388-150-200(7), when applicable.

[Statutory Authority: RCW 74.15.020, 98-24-052, § 388-150-470, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-470, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-470, filed 11/20/90, effective 12/21/90.]

WAC 388-150-480 Reporting of death, injury, illness, epidemic, or child abuse. The licensee or staff shall report immediately:

(1) A death, serious injury requiring medical treatment, or illness requiring hospitalization of a child in care, by telephone and in writing, to the parent, licensor, and child's social worker, if any;

(2) An instance when the licensee or staff has reason to suspect the occurrence of physical, sexual, or emotional child abuse, child neglect, or child exploitation as required under chapter 26.44 RCW, by telephone, to child protective services or local law enforcement; or

(3) An occurrence of food poisoning or communicable disease, as required by the state board of health, by telephone, to the local public health department.

[Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-480, filed 11/20/90, effective 12/21/90.]

WAC 388-150-490 Reporting of circumstantial changes. A child day care center license is valid only for the address, person, and organization named on the license. The licensee shall promptly report to the licensor any major changes in administrative staff, program, or premises affect-

ing the center's classification, delivery of safe, developmentally appropriate services, or continued eligibility for licensure. A major change includes the:

(1) Center's address, location, space, or phone number;

(2) Maximum number and age ranges of children the licensee wishes to serve as compared to current license specifications;

(3) Number and qualifications of the center's staffing pattern that may affect staff competencies to implement the specified program, including:

(a) Change of ownership, chief executive, director, or program supervisor; and

(b) The death, retirement, or incapacity of the licensee.

(4) Name of the licensed corporation, or name by which the center is commonly known, or changes in the center's articles of incorporation and bylaws;

(5) Occurrence of a fire, major structural change, or damage to the premises; and

(6) Plans for major remodeling of the center, including planned use of space not previously department approved.

[Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-490, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-490, filed 11/20/90, effective 12/21/90.]

WAC 388-150-500 Posting requirements. (1) The licensee shall post the following items, clearly visible to the parent and staff:

(a) The center's child care license issued under this chapter;

(b) A schedule of regular duty hours with the names of staff;

(c) A typical activity schedule, including operating hours and scheduled mealtimes;

(d) Meal and snack menus;

(e) Evacuation plans and procedures, including a diagram of exiting routes;

(f) Emergency telephone numbers near the telephone; and

(g) Nondiscrimination poster.

(2) For the staff, the licensee shall post:

(a) Dietary restrictions and nutrition requirements for particular children;

(b) Handwashing practices; and

(c) Diaper changing procedures, if applicable.

[Statutory Authority: RCW 74.15.020 and 74.15.030, 93-18-001 (Order 3623), § 388-150-500, filed 8/18/93, effective 9/18/93. Statutory Authority: RCW 74.15.030, 90-23-078 (Order 3103), § 388-150-500, filed 11/20/90, effective 12/21/90.]

Chapter 388-151 WAC

SCHOOL-AGE CHILD CARE CENTER MINIMUM LICENSING REQUIREMENTS

WAC

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WAC 388-151-010 Definitions. As used and defined under this chapter:

"Capacity" means the maximum number of children the licensee is authorized to have on the premises at a given time.

"Child abuse or neglect" means the injury, sexual abuse, sexual exploitation, or negligent treatment or maltreatment of a child by any person under circumstances indicating the child's health, welfare, or safety is harmed thereby.

"Department" means the state department of social and health services (DSHS), the organization vested with the legal authority to regulate and certify school-age child care centers.

"Department of health" means the state department of health.

"License" means a permit issued by the department authorizing by law the licensee to operate a school-age child care center and affirming the licensee meets requirements under licensure.

"Licensee" means the person, organization, or legal entity responsible for operating the center.

"Licensor" means the person employed by the department to regulate and license a school-age child care center.

"Premises" means the building where the center is located and the adjoining grounds over which the licensee has control.

(1999 Ed.)

"School-age child" means a child five years of age through twelve years of age attending a public or private school.

"School-age child care center" means a program operating in a facility other than a private residence, accountable for school-age children when school is not in session. It shall meet department licensing requirements, provide adult-supervised care, and a variety of developmentally appropriate activities.

"Staff" means a child care giver or a group of child care givers employed by the licensee to supervise a child served at the center.

"The Washington state training and registry system (STARS)" means the entity approved by the department to determine the classes, courses, and workshops licensees and staff may take to satisfy training requirements.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-151-010, filed 11/25/98, effective 12/26/98. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-010, filed 12/30/92, effective 1/30/93.]

WAC 388-151-020 Scope of licensing. (1) The person or organization operating a school-age child care center shall be subject to licensing as authorized under chapter 74.15 RCW.

(2) The person or organization operating a school-age child care center and qualifying for exemption from requirements of this chapter under RCW 74.15.020(4) shall not be subject to licensure. The person or organization claiming an exemption shall provide the department proof of entitlement to the exemption at the licensor's request.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-020, filed 12/30/92, effective 1/30/93.]

WAC 388-151-040 Local ordinances and codes. (1) The department shall issue or deny a license on the basis of the applicant's compliance with school-age child care licensing and procedural requirements.

(2) The licensee or applicant shall be responsible for compliance with city ordinances and county codes, such as zoning and building regulations.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-040, filed 12/30/92, effective 1/30/93.]

WAC 388-151-050 Waivers. (1) In an individual case, the department, for good cause, may waive a specific requirement and approve an alternate method for the licensee or applicant to achieve the specific requirement's intent if the:

(a) Licensee or applicant submits to the department a written waiver request fully explaining the circumstances necessitating the waiver; and

(b) Department determines waiver approval will not jeopardize the safety or welfare of the child in care or detract from the quality of licensee-delivered services.

(2) The department may approve a waiver request only for a specific purpose or child and for a specific period of time not exceeding the expiration date of the license.

(3) The department may limit or restrict a license issued to a licensee or an applicant in conjunction with a waiver.

(4) The licensee shall maintain on the premises a copy of the department's written waiver approval.

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(5) The department's denial of a licensee's or applicant's waiver request shall not be subject to appeal under chapter 34.05 RCW.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-050, filed 12/30/92, effective 1/30/93.]

WAC 388-151-070 Applicant and reapplication for licensing-investigation. (1) The person or organization applying for a licensee or relicensure under this chapter and responsible for operating the center shall comply with application procedures the department prescribes and submit to the department:

(a) A completed department-supplied application for school-age child care center license, including attachments, ninety or more days before the:

- (i) Expiration of a current license;
- (ii) Opening date of a center;
- (iii) Relocation of a center; or
- (iv) Change of the licensee.

(b) A completed criminal history and background inquiry form for each staff person or volunteer having unsupervised or regular access to the child in care; and

(c) The licensing fee.

(2) In addition to the required application materials specified under subsection (1) of this section, the applicant for initial licensure shall submit to the department:

(a) An employment and education resume of the person responsible for the active management of the center and of the site coordinator;

(b) Diploma or education transcript copies of the director and site coordinator; and

(c) Three professional references each for the licensee, director, and site coordinator.

(3) The applicant for a license under this chapter shall be twenty-one years of age or older.

(4) The department may, at any time, require additional information from the applicant, licensee, staff person, volunteer, member of their household, and other persons having access to the child in care as the department deems necessary including, but not limited to:

- (a) Sexual deviancy evaluations;
- (b) Substance and alcohol abuse evaluations;
- (c) Psychiatric evaluations;
- (d) Psychological evaluations; and
- (e) Medical evaluations.

(5) The department may perform investigations of the applicant, licensee, staff person, volunteer, member of their household, and other person having access to the child in care as the department deems necessary, including accessing criminal histories and law enforcement files.

(6) The applicant shall conform to rules and regulations approved or adopted by the:

(a) Department of health, promoting the health of the child in care, contained in this chapter; and

(b) State fire marshal's office, establishing standards for fire prevention and protection of life and property from fire, under chapter 212-56A WAC.

(7) The department shall not issue a license to the applicant until the department of health and the state fire marshal's office have certified or inspected and approved the center.

(8) The department may exempt a school site possessing a fire safety certification signed by the local fire official within six months prior to licensure from the requirement to receive an additional fire safety inspection by the state fire marshal's office.

(9) The licensee shall submit a completed plan of deficiency correction to the department of health and the department licensor prior to issuance of the licensee, when required.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-070, filed 12/30/92, effective 1/30/93.]

WAC 388-151-080 Licensed capacity. (1) The department shall issue the applicant or licensee a license for a specific number of children dependent on the:

(a) Department's evaluation of the center's premises, equipment, and physical accommodations;

(b) Number and skills of the licensee, staff, and volunteers; and

(c) Ages and characteristics of the children served.

(2) The department:

(a) Shall not issue the applicant or licensee a license to care for more children than permitted under this chapter; and

(b) May issue the applicant or licensee a license to care for fewer children than the center's maximum capacity.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-080, filed 12/30/92, effective 1/30/93.]

WAC 388-151-085 Initial license. (1) The department may issue an initial license to an applicant not currently licensed to provide child day care when the applicant:

(a) Can demonstrate compliance with the rules contained in this chapter pertaining to the health and safety of the child in care; but

(b) Cannot demonstrate compliance with the rules pertaining to:

- (i) Staff-child interactions,
- (ii) Group size and staff-child ratios,
- (iii) Behavior management and discipline,
- (iv) Activity programs,

(v) Child records and information, and

(vi) Other rules requiring department observation of the applicant's ability to comply with rules.

(c) Can provide a plan, acceptable to the department, to comply with rules found in subsection (1)(b) of this section.

(2) The department may issue an initial license to an applicant for a period not to exceed six months, renewable for a period not to exceed two years.

(3) The department shall evaluate the applicant's ability to comply with all rules contained in this chapter during the period of initial licensure prior to issuing a full license.

(4) The department may issue a full license to the applicant demonstrating compliance with all rules contained in this chapter at any time during the period of initial licensure.

(5) The department shall not issue a full license to the applicant who does not demonstrate the ability to comply with all rules contained in this chapter during the period of initial licensure.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-085, filed 10/1/96, effective 11/1/96.]

WAC 388-151-090 License denial, suspension, or revocation. (1) Before granting a license and as a condition for continuance of a license, the department shall consider the ability of the applicant and licensee to meet the requirements of this chapter. If more than one person is the applicant or licensee, the department:

(a) Shall consider their qualifications separately and jointly; and

(b) May deny, suspend, revoke, or not renew the license based on the failure of one of the persons to meet the requirements.

(2) The department shall deny, suspend, revoke, or not renew the license of a person who:

(a) Has abused, neglected, or sexually exploited a child as those acts or omissions are defined in RCW 26.44.020 and WAC 388-15-130, is ineligible to provide care because of a criminal history under chapter 388-330 WAC, or allows such a person on the premises;

(b) Commits or was convicted of a felony reasonably related to the competency of the person to meet the requirements of this chapter;

(c) Engages in illegal use of a drug or excessive use of alcohol;

(d) Commits, permits, aids, or abets the commission of an illegal act on the premises;

(e) Commits, permits, aids, or abets the abuse, neglect, exploitation, or cruel or indifferent care to a child in care;

(f) Refuses to permit an authorized representative of the department, state fire marshal's office, or department of health to inspect the premises; or

(g) Refuses to permit an authorized representative of the department or the department of health access to records related to operation of the center or to interview staff or a child in care.

(3) The department may deny, suspend, revoke, or not renew a license of a person who:

(a) Seeks to obtain or retain a license by fraudulent means or misrepresentation including, but not limited to:

(i) Making a materially false statement on the application; or

(ii) Omitting material information on the application.

(b) Provides insufficient staff in relation to the number, ages, or characteristics of children in care;

(c) Allows a person unqualified by training, experience, or temperament to care for or be in contact with a child in care;

(d) Violates any condition or limitation on licensure including, but not limited to:

(i) Permitting more children on the premises than the number for which the center is licensed; or

(ii) Permitting on the premises a child of an age different from the ages for which the center is licensed.

(e) Fails to provide adequate supervision to a child in care;

(f) Demonstrates an inability to exercise fiscal responsibility and accountability with respect to operation of the center;

(g) Misappropriates property of a child in care;

(h) Knowingly permits on the premises an employee or volunteer who has made a material misrepresentation on an application for employment or volunteer service;

(i) Refuses or fails to supply necessary, additional department requested information; or

(j) Fails to comply with any provision of chapter 74.15 RCW or this chapter.

(4) The department shall not issue a license to a person who has been denied, suspended, revoked, or not renewed a license to operate a facility for the care of the children or adults, in this state or elsewhere, unless the person demonstrates by clear, cogent, and convincing evidence the person has undertaken sufficient corrective action or rehabilitation to warrant public trust and to operate the center in accordance with the rules of this chapter.

(5) The department's notice of a denial, revocation, suspension, or modification of a license and the applicant's or licensee's right to a hearing, shall be governed under RCW 43.20.205.

[Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-151-090, filed 4/26/96, effective 5/27/96. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-090, filed 12/30/92, effective 1/30/93.]

WAC 388-151-092 Civil penalties. (1) Before imposing a civil penalty, the department shall provide written notification by personal service, including by the licensor, or certified mail which shall include:

(a) A description of the violation and citation of the applicable requirement or law;

(b) A statement of what is required to achieve compliance;

(c) The date by which the department requires compliance;

(d) The maximum allowable penalty if timely compliance is not achieved;

(e) The means to contact any technical assistance services provided by the department or others; and

(f) Notice of when, where, and to whom a request to extend the time to achieve compliance for good cause may be filed with department.

(2) The length of time in which to comply shall depend on:

(a) The seriousness of the violation;

(b) The potential threat to the health, safety and welfare of children in care; or

(c) Previous opportunities to correct the deficiency.

(3) The department may impose a civil penalty based on but not limited to these reasons:

(a) The child care center has previously been subject to an enforcement action for the same or similar type of violation of the same statute or rule; or

(b) The child care center has previously been given notice of the same or similar type of violation of the same statute or rule; or

(c) The violation represents a potential threat to the health, safety, and/or welfare of children in care.

(4) The department may impose a civil penalty in addition to or in conjunction with other disciplinary actions

against a child care license including probation, suspension, or other action.

(5) The civil fine shall be payable twenty-eight days after receipt of the notice or later as specified by the department.

(6) The fine may be forgiven if the agency comes into compliance during the notification period.

(7) The center or person against whom the department assesses a civil fine has a right to an adjudicative proceeding as governed by RCW 43.20A.215.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-092, filed 10/1/96, effective 11/1/96.]

WAC 388-151-093 Civil penalties—Amount of penalty. Whenever the department imposes a civil monetary penalty per WAC 388-151-092(3), the department shall impose a penalty of two hundred and fifty dollars per violation per day. The department may assess and collect the penalty with interest for each day of noncompliance.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-093, filed 10/1/96, effective 11/1/96.]

WAC 388-151-094 Civil penalties—Posting of notice of penalty. (1) The licensee shall post the final notice of a civil penalty in a conspicuous place in the facility.

(2) The notice shall remain posted until payment is received by the department.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-094, filed 10/1/96, effective 11/1/96.]

WAC 388-151-095 Civil penalties—Unlicensed programs. Where the department has determined that an agency is operating without a license, the department shall send written notification by certified mail or other means showing proof of service. This notification shall contain the following:

(1) Advising the agency of the basis of determination of providing child care without a license and the need to be licensed by the department;

(2) The citation of the applicable law;

(3) The assessment of seventy-five dollars per day penalty for each day unlicensed care is provided. The fine would be effective and payable within thirty days of receipt of the notification;

(4) How to contact the office of child care policy;

(5) The need to submit an application to the office of child care policy within thirty days of receipt of the notification;

(6) That the penalty may be forgiven if the agency submits an application within thirty days of the notification; and

(7) The right of an adjudicative proceeding as a result of the assessment of a monetary penalty and the appropriate procedure for requesting an adjudicative proceeding.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-095, filed 10/1/96, effective 11/1/96.]

WAC 388-151-096 Civil penalties—Separate violations. Each violation of a law or rule constitutes a separate violation and may be penalized as such. A penalty may be imposed for each day the violation continues.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-096, filed 10/1/96, effective 11/1/96.]

WAC 388-151-097 Civil penalties—Penalty for non-payment. Penalty for nonpayment. The department may suspend, revoke or not renew a license for failure to pay a civil monetary penalty it has assessed within ten days after such assessment becomes final.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-097, filed 10/1/96, effective 11/1/96.]

WAC 388-151-098 Probationary license. (1) The department shall base the decision as to whether a probationary license will be issued upon the following factors:

- (a) Willful or negligent noncompliance by the licensee,
- (b) History of noncompliance,
- (c) Extent of deviation from the requirements,
- (d) Evidence of a good faith effort to comply,
- (e) Any other factors relevant to the unique situation.

(2) Where the negligent or willful violation of the licensing law does not present an immediate threat to the health and well-being of the children but would be likely to do so if allowed to continue, a probationary license may be issued as well as civil penalties or other sanctions. Such situations may include:

- (a) Substantiation that a child (or children) was abused or neglected while in the care of the center,
- (b) Disapproved fire safety or sanitation report,
- (c) Use of unauthorized space for child care,
- (d) Inadequate supervision of children,
- (e) Understaffing for the number of children in care,
- (f) Noncompliance with requirements addressing:
 - (i) Children's health,
 - (ii) Proper nutrition,
 - (iii) Discipline,
 - (iv) Emergency medical plan,
 - (v) Sanitation and personal hygiene practices.

(3) Licensee required to notify parents when a probationary licensed is issued:

(a) The licensee shall notify the parents or guardians of all children in care that it is in probationary status within five working days of receiving notification he or she has been issued a probationary license;

(b) The notification shall be in writing and shall be approved by the department prior to being sent;

(c) The licensee shall provide documentation to the department that parents or guardians of all children in care have been notified within ten working days of receiving notification that he or she has been issued a probationary license;

(d) The department may issue a probationary license for up to six months, and at the discretion of the department it may be extended for an additional six months.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-151-098, filed 10/1/96, effective 11/1/96.]

WAC 388-151-100 Activity program. (1) The licensee shall implement an activity program designed to meet the developmental, cultural, and individual needs of the child served. The licensee shall ensure the program contains a range of learning experiences for the child to:

- (a) Gain self-esteem, self-awareness, self-control, and decision-making abilities;

- (b) Develop socially, emotionally, intellectually, and physically;
- (c) Learn about nutrition, health, and personal safety; and
- (d) Experiment, create, and explore.

(2) The licensee shall ensure the center's program offers variety and options including a balance between:

- (a) Child-initiated and staff-initiated activities;
- (b) Free play and organized events;
- (c) Individual and group activities; and
- (d) Quiet and active experiences.

(3) The licensee shall ensure the center's program affords the child daily opportunities for small and large muscle activities and outdoor play.

(4) The licensee shall operate the center's program under a regular schedule of activities with allowances for a variety of special events. The licensee shall implement a planned program of activities as evidenced by a current, written activity schedule and afford staff classroom planning time.

(5) The licensee shall manage child and staff movements from one planned activity or care area to another to achieve smooth, unregimented transitions by:

- (a) Establishing familiar routines;
- (b) Contributing to learning experiences; and
- (c) Maintaining staff-to-child ratio and group size guidelines.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-100, filed 12/30/92, effective 1/30/93.]

WAC 388-151-110 Learning and play materials. The licensee shall provide the child a variety of easily accessible, developmentally appropriate equipment and materials of sufficient quantity to implement the center's program. The licensee shall ensure material is culturally relevant and promotes:

- (1) Social development;
- (2) Communication ability;
- (3) Self-help skills;
- (4) Large and small muscle development; and
- (5) Creative expression.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-110, filed 12/30/92, effective 1/30/93.]

WAC 388-151-120 Staff-child interactions. (1) The licensee shall furnish the child a nurturing, respectful, supportive, and responsive environment through frequent interactions between the child and staff:

- (a) Supporting the child in developing an understanding of self and others by assisting the child to share ideas, experiences, and feelings;
- (b) Providing age-appropriate opportunities for growth and development of the child's social and communication skills, including encouraging the child to ask questions;
- (c) Helping the child solve problems;
- (d) Fostering creativity and independence in routine activities, including showing tolerance for mistakes; and
- (e) Treating equally all children in care regardless of race, religion, culture, sex, and handicapping condition.

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(2) The licensee shall furnish the child a pleasant and social atmosphere at meal and snack times. Staff shall provide good models for nutrition habits and social behavior.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-120, filed 12/30/92, effective 1/30/93.]

WAC 388-151-130 Behavior management and discipline. (1) The licensee shall guide the child's behavior based on an understanding of the individual child's needs and stage of development. The licensee shall support the child's developmentally appropriate social behavior, self-control, and respect for the rights of others.

(2) The licensee shall ensure behavior management and discipline practice are fair, reasonable, consistent, and related to the child's behavior. Staff shall not administer cruel, unusual, hazardous, frightening, or humiliating discipline.

(3) The licensee shall be responsible for implementing the behavior management and discipline practices of the center.

(4) The licensee shall prohibit and prevent by any person on the premises:

(a) Biting, jerking, shaking, spanking, slapping, hitting, striking, or kicking the child, or other means of inflicting physical or emotional pain, or causing bodily harm;

(b) The use of a physical restraint method injurious to the child;

(c) The use of a mechanical restraint, locked time-out room, or closet;

(d) The use of verbal abuse; or

(e) The withholding of food as a punishment.

(5) In emergency situations, the staff person competent to use restraint methods may use limited physical restraint when:

(a) Protecting a person on the premises from physical injury;

(b) Obtaining possession of a weapon or other dangerous object; or

(c) Protecting property from serious damage.

(6) The licensee shall document any incident involving the use of physical restraint.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-130, filed 12/30/92, effective 1/30/93.]

WAC 388-151-150 Evening and nighttime care. (1) For the center offering school-age child care during evening and nighttime hours, the licensee shall, in addition to meeting daytime regulations, adapt the program, equipment, and staffing pattern to meet the physical and emotional needs of the child away from home at night.

(2) The licensee shall maintain the same staff-to-child ratio in effect during daytime care. At all times, staff shall keep the child within continuous visual or auditory range.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-150, filed 12/30/92, effective 1/30/93.]

WAC 388-151-160 Off-site trips. (1) The licensee may transport or permit the supervised off-site travel of the child to participate in field trips or engage in other off-site activities only with written parent consent.

(2) The parent's consent may be:

- (a) For a specific date and trip; or
- (b) A blanket authorization describing the full range of trips the child may take. In such case, the licensee shall notify the parent in advance about the trip.
- (3) For group field trips, the licensee shall ensure:
 - (a) Emergency information and medical treatment authorization for each child in the group is present;
 - (b) A first aid kit is available;
 - (c) A written list of children participating is maintained; and
 - (d) Required staff-child ratios are maintained.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-160, filed 12/30/92, effective 1/30/93.]

WAC 388-151-165 Transportation. When the licensee furnishes transportation for the child in care:

- (1) The licensee shall ensure that the motor vehicle is maintained in a safe operating condition and is approved by the Washington state patrol, when applicable;
- (2) The licensee or driver shall carry liability and medical insurance;
- (3) The driver shall have a current driver's license, valid for the classification of motor vehicle operated, and current first aid and CPR certification;
- (4) The licensee shall ensure a minimum of one staff person other than the driver is present in the motor vehicle, when necessary, to ensure staff-to-child ratio compliance; and
- (5) The licensee shall ensure the number of passengers does not exceed the seat belt capacity of the motor vehicle.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-165, filed 12/30/92, effective 1/30/93.]

WAC 388-151-170 Parent communication. (1) The licensee shall orally:

- (a) Explain to the parent the center's policies and procedures;
- (b) Orient the parent to the center's philosophy, program, and facilities;
- (c) Communicate to the parent issues relating to the child's care and individual practices concerning the child's special needs; and
- (d) Encourage parent participation in center activities.
- (2) The licensee shall give the parent the following written policy and procedure information:
 - (a) Enrollment and admission requirements;
 - (b) The fee and payment plan;
 - (c) A typical activity schedule, including hours of operation;
 - (d) Meals and snacks served, including guidelines on food bought from the child's home;
 - (e) Signing in and signing out requirements;
 - (f) Child abuse reporting law requirements;
 - (g) Behavior management and discipline;
 - (h) Nondiscrimination statement;
 - (i) Religious activities, if any;
 - (j) Transportation and field trip arrangements;
 - (k) Policy on homework, study time, and space necessary to accommodate these activities;
 - (l) Practices concerning an ill child;
 - (m) Medication management; and

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- (n) Medical emergencies.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-170, filed 12/30/92, effective 1/30/93.]

WAC 388-151-180 Staff pattern and qualifications.

- (1) General qualifications. The licensee, staff, volunteer, and other person associated with the operation of the center who has access to the child in care shall:
 - (a) Be of good character;
 - (b) Demonstrate the understanding, ability, personality, emotional stability, and physical health suited to meet the cultural, emotional, mental, physical, and social needs of the child in care; and
 - (c) Not have committed or been convicted of child abuse or any crime involving harm to another person.
- (2) Program director. The licensee shall serve as or employ a director responsible for the overall management of the center's facility and operation. The director shall:
 - (a) Be twenty-one years of age or older;
 - (b) Serve as administrator of the center, ensuring compliance with licensing requirements;
 - (c) Have knowledge of development of school-age children as evidenced by professional references, education, experience, and on-the-job performance;
 - (d) Have the management and supervisory skills necessary for the proper administration for the center including:
 - (i) Record maintenance;
 - (ii) Financial management; and
 - (iii) Maintenance of positive relationships with staff, children, parents, and the community.
 - (e) Employ, provide, or arrange for fulfillment of clerical, accounting, maintenance, transportation, and food service responsibilities so the child care staff is free to concentrate on program implementation and maintaining the required staff-to-child ratio;
 - (f) Have completed thirty or more college quarter credits in early childhood education/child development, elementary education, or possess an equivalent educational background in courses such as recreation, physical education, education, music, art, home economics, psychology, or social services;
 - (g) Have two or more years of successful experience working with school-age children as evidenced by professional references and on-the-job performance;
 - (h) Have planning, coordination, and supervisory skills to implement a high quality, developmentally appropriate program; and
 - (i) Have completed one of the following prior to or within the first six months of licensure or employment except as provided in subsection (2)(i) of this section:
 - (i) Twenty clock hours or two college quarter credits of basic training. Training shall be approved by the Washington state training and registry system (STARS); or
 - (ii) Current child development associate (CDA) or equivalent credential or twelve or more college quarter credits in child development, early childhood education, school-age care, elementary education, special education or recreation; or
 - (iii) An associate or arts (AA) or associate of applied science (AAS) or higher college degree in early childhood

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education, child development, school-age care, elementary education, special education, or recreation.

(j) Program directors who are already employed or licensed on the effective date of this rule must complete the training required in WAC 388-151-180 (2)(h) prior to or within twelve months after the effective date of this rule.

(3) Site coordinator. The licensee may employ a site coordinator responsible for program planning and implementation. The site coordinator shall be under the regular supervision of the program director.

(4) The site coordinator and program director may be one and the same person when qualified for both positions. The site coordinator shall:

(a) Be twenty-one years of age or older;

(b) Have completed thirty or more college quarter credits in early childhood education/child development, elementary education, or possess an equivalent educational background in courses such as recreation, physical education, education, music, art, psychology, or social services;

(c) Serve as staff supervisor;

(d) Have demonstrated knowledge in:

(i) Behavior management skills specific to school-age children;

(ii) Program management skills; and

(iii) School-age child activity planning and coordinating skills.

(e) Have a minimum of two years experience working with school-age children, or possess equivalent experience.

(f) Have completed one of the following prior to or within the first six months of licensure or employment except as provided in subsection (4)(g) of this section:

(i) Twenty clock hours or two college quarter credits of initial training. Training shall be approved by the Washington state training and registry system (STARS); or

(ii) Current child development associate (CDA) or equivalent credential or twelve or more college quarter credits in early childhood education, child development, school-age care, elementary education, special education or recreation; or

(iii) Forty-five or more college quarter credits in early childhood education, child development, school-age care, elementary education, special education, or recreation; or

(iv) An associate of arts (AA) or associate of applied science (AAS) or higher college degree in early childhood education, child development, school-age care, elementary education, special education, or recreation.

(g) Site coordinators who are already employed on the effective date of this rule must complete the training required in WAC 388-151-180 (4)(f) prior to or within twelve months after the effective date of this rule.

(5) The program director or site coordinator shall normally be on the premises while the child is in care. If temporarily absent from the center, the director and site coordinator shall leave a competent, designated staff person in charge.

(6) The director and site coordinator may also serve as child care staff when such role does not interfere with the director's or site coordinator's management and supervisory responsibilities.

(7) Center staffing. The licensee may employ a lead school-age child care staff person to be in charge of a child or a group of children. Lead school-age child care staff shall:

(a) Be eighteen years of age or older;

(b) Possesses a high school education or equivalent;

(c) Have school-age child development knowledge and experience; and

(d) Have the ability to implement the activity program.

(8) The licensee may employ a child care assistant, volunteer, or trainee. The assistant, volunteer, or trainee shall support staff. The school age child care assistant, volunteer, or trainee shall:

(a) Be sixteen years of age or older; and

(b) Care for the child only under direct supervision.

(9) The licensee shall ensure no person under eighteen years of age is assigned sole responsibility for a group of children. The assistant, eighteen years of age or older, may be assigned sole responsibility for a child or group of children for a brief period of time.

(10) The licensee may count the assistant, volunteer, or trainee in the staff-to-child ratio when that person meets staff requirements.

[Statutory Authority: RCW 74.15.030, 98-24-052, § 388-151-180, filed 11/25/98, effective 12/26/98. Statutory Authority: Chapter 74.15 RCW, 93-02-020 (Order 3493), § 388-151-180, filed 12/30/92, effective 1/30/93.]

WAC 388-151-190 Group size and staff-child ratios.

(1) The licensee shall maintain, at minimum, a 1:15 staff-child ratio and a maximum group size of thirty or fewer children.

(2) The licensee shall conduct activities for each group in a specific classroom or other defined space within a larger area.

(3) The licensee shall ensure each group is under the supervision of a qualified staff person or team of staff.

(4) The department may approve reasonable variations to group size limitations if the licensee maintains required staff-to-child ratios, dependent on:

(a) Staff qualifications;

(b) Program structure; and

(c) Usable space.

(5) The licensee shall ensure staff keep each child within continuous visual or auditory range, except when the child uses the toilet.

(6) When only one staff person is present, the licensee shall ensure a second staff person is readily available in case of an emergency.

(7) The licensee shall ensure that each group of children is supervised by a staff person who has completed one of the following prior to or within the first six months of employment except as provided in subsection (8) of this section:

(a) Twenty clock hours or two college quarter credits of initial training. Training shall be approved by the Washington state training and registry system (STARS); or

(b) Current child development associate (CDA) or equivalent credential or twelve or more college quarter credits in early childhood education, child development, school-age care, elementary education, special education, or recreation; or

(c) An associate of arts (AA) or associate of applied science (AAS) or higher college degree in early childhood education, child development, school-age care, elementary education, special education, or recreation.

(8) Staff persons who are required to complete the training described in WAC 388-151-190(7) and who are already employed on the effective date of this rule must complete the training prior to or within twelve months after the effective date of this rule.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-151-190, filed 11/25/98, effective 12/26/98. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-190, filed 12/30/92, effective 1/30/93.]

WAC 388-151-200 Staff development, orientation, and training. (1) The licensee shall have an orientation system making the employee, volunteer, and trainee aware of program policies and practices. The licensee shall provide staff an orientation including, but not limited to:

- (a) Licensing rules required under this chapter;
- (b) Goals and philosophy of the center;
- (c) Planned daily activities and routines;
- (d) Age-appropriate child guidance and behavior management methods;
- (e) Child abuse and neglect prevention, detection, and reporting policies and procedures;
- (f) Special health and developmental needs of the individual child;
- (g) Fire prevention and safety procedures; and
- (h) Personnel policies.

(2) The licensee shall provide or arrange regular training opportunities for the child care staff to:

- (a) Promote ongoing employee education;
- (b) Enhance practice skills;
- (c) Increase cultural awareness; and
- (d) Accommodate special health and developmental needs of the individual child.

(3) The licensee shall conduct periodic staff meetings for planning and coordination purposes.

(4) The licensee shall ensure:

(a) A staff person with basic, standard, current first aid and cardiopulmonary resuscitation (CPR) training, or department of health approved training is present at all times while the child is in care; and

(b) Staff's CPR training includes methods appropriate for school-age children in care.

(5) The licensee shall provide or arrange appropriate education and training for child care staff on the prevention and transmission of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

(6) The licensee shall ensure the person preparing full meals for the center has a valid food handler permit.

(7) The licensee shall ensure that the director, site coordinator and, where the program serves more than one group of children, at least one staff person for every group of children, complete ten clock hours or one college quarter credit of training annually, beginning one year after licensure or employment in a licensed child care facility, complete ten clock hours or one college quarter credit of training approved by Washington state registry and training system (STARS). For those already employed or licensed on the effective date

of this rule, the requirement for annual training shall begin one year after the effective date of the rule.

For the director and the site coordinator, five of the ten hours of training shall be in program management and administration.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-151-200, filed 11/25/98, effective 12/26/98. Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-200, filed 12/30/92, effective 1/30/93.]

WAC 388-151-210 Health care plan. (1) The licensee shall maintain current written health policies and procedures for staff orientation and use, and for the parent.

(2) The licensee shall ensure the health care plan includes, but is not limited to, information about the center's procedures concerning:

- (a) Communicable disease prevention, reporting, and management;
- (b) Action taken for medical emergencies;
- (c) First aid;
- (d) Care of minor illnesses;
- (e) Medication management;
- (f) General hygiene practices;
- (g) Hand washing practices; and
- (h) Food and food services.

(3) The licensee shall use the services of an advisory physician, physician's assistant, or registered nurse to assist in the development and approval of the center's health care plan.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-210, filed 12/30/92, effective 1/30/93.]

WAC 388-151-220 Health supervision and infectious disease prevention. (1) Before or on the child's first day of attendance, the licensee shall have on file a record of immunization status.

(2) Staff shall observe the child daily for signs of illness. The licensee shall care for or discharge home the ill child based on the center's policies concerning the ill child.

(3) If a child becomes ill while in care:

- (a) The licensee shall furnish a separate care area with an appropriate rest surface and bedding, as needed; and
- (b) Staff shall sanitize equipment the child uses if staff suspects the child has a communicable disease.

(4) The licensee may use the separate care room or area for other purposes when not needed for separation of the child.

(5) Staff shall ensure the child washes hands:

- (a) Before the child eats;
- (b) Before the child participates in food activities; and
- (c) After the child's toileting.

(6) Staff shall follow the center's policies for cleaning and disinfecting the environment.

(7) The licensee shall have extra clothing available for circumstances arising during outdoor play.

(8) Staff shall ensure the child does not share personal hygiene or grooming items.

(9) Each center employee, volunteer, and other person having regular contact with the child in care shall have results of a negative tuberculin (TB) skill test, by the Mantoux method, or results of a chest x-ray, on file upon employment,

unless such is against medical advice. Periodic retesting is not required.

(10) The licensee shall not permit the person with a reportable communicable disease to be on duty in the center or have contact with the child in care unless a health care provider approves this in writing.

(11) Staff shall wash hands:

- (a) After personal toileting;
- (b) After attending to an ill child;
- (c) After nose blowing;
- (d) After smoking; and
- (e) Before serving or preparing food.

[Statutory Authority: Chapter 74.15 RCW, 93-02-020 (Order 3493), § 388-151-220, filed 12/30/92, effective 1/30/93.]

WAC 388-151-230 Medication management. The center may have a policy of not giving medication to the child in care. If the center's health care plan includes giving medication to the child in care, the licensee:

(1) Shall give medications, prescription and nonprescription, only on the written approval of a parent, person, or agency having authority by court order to approve medical care;

(2) Shall give prescription medications:

- (a) Only as specified on the prescription label; or
- (b) As authorized, in writing, by a physician or other person legally authorized to prescribe medication.

(3) Shall give the following classifications of nonprescription medications, with written parent authorization, only at the dose, duration, and method of administration specified on the manufacturer's label for the age or weight of the child needing the medication:

- (a) Antihistamines;
- (b) Nonaspirin fever reducers/pain relievers;
- (c) Nonnarcotic cough suppressants;
- (d) Decongestants;

(e) Anti-itching ointments or lotions, intended specifically to relieve itching;

(f) Diaper ointments and powders, intended specifically for use in the diaper area of the child; and

(g) Sun screen.

(4) Shall give other nonprescription medication:

(a) Not included in the categories listed in subsection (3) of this section; or

(b) Taken differently than indicated on the manufacturer's label; or

(c) Lacking labeled instructions, only when disbursement of the nonprescription medication is as required under subsection (4) (a), (b), and (c) of this section:

(i) Authorized, in writing, by a physician; or

(ii) Based on established medical policy approved, in writing, by a physician or other person legally authorized to prescribe medication.

(5) Shall accept from the child's parent, guardian, or responsible relative only medicine in the original container, labeled with:

- (a) The child's first and last names;
- (b) The date the prescription was filled; or
- (c) The medication's expiration date; and

(d) Legible instructions for administration, such as manufacturer's instructions or prescription label.

(6) Shall keep medication, refrigerated or nonrefrigerated, in an orderly fashion and inaccessible to the child;

(7) Shall store external medication in a compartment separate from internal medication;

(8) Shall keep a record of medication disbursed;

(9) Shall return to the parent or other responsible party, or shall dispose of medications no longer being taken; and

(10) May, at the licensee's option, permit self-administration of medication by a child in care if the:

(a) Child is physically and mentally capable of properly taking medication without assistance;

(b) Licensee includes in the child's file a parental or physician's written statement of the child's capacity to take medication with assistance; and

(c) Licensee ensures the child's medications and other medical supplies are stored so the medications and medical supplies are inaccessible to another child in care.

[Statutory Authority: Chapter 74.15 RCW, 93-02-020 (Order 3493), § 388-151-230, filed 12/30/92, effective 1/30/93.]

WAC 388-151-240 Nutrition. (1) The licensee shall provide food meeting the nutritional needs of the child in care, taking into consideration the child's:

(a) Age and development level;

(b) Cultural background; and

(c) Handicapping condition.

(2) The licensee shall provide only pasteurized milk or pasteurized milk products.

(3) The licensee may serve the school-age child powdered Grade A milk, provided the licensee completes the dry milk mixture, service, and storage in a safe and sanitary manner.

(4) The licensee may furnish the child nutrient concentrates, nutrient supplements, a modified diet, or an allergy diet only with the written permission of the child's health care provider. The licensee shall obtain from the parent or the child's health care provider a written list of foods the child cannot consume.

(5) The licensee shall:

(a) Record food and portion sizes planned and served; and

(b) Post menus showing two weeks or more of food variety before repeating menus.

(6) The licensee may make nutritional substitutions of comparable nutrient value to the menu.

(7) The licensee shall use the following meal pattern to furnish food in age-appropriate servings, providing the child:

(a) Arrives on the premises before 7:00 a.m. access to a breakfast;

(b) In care for one to three hours before or after school a snack; and

(c) Food at intervals not less than two hours and not more than three and one-half hours apart.

(8) The licensee shall furnish the child in care food complying with the meal pattern of the United States Department of Agriculture Child and Adult Care Food Program or the National School Lunch Program.

(9) The child's snacks shall include one or more dairy or protein source provided daily, and contain a minimum of two of the following four components at each snack:

- (a) A dairy product;
- (b) A protein food;
- (c) Bread or bread alternate; or
- (d) Fruit or vegetable or juice containing a minimum of fifty percent real juice.

(10) The licensee shall have available food supplies to supplement food deficient in meeting nutrition requirements brought from the child's home.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-240, filed 12/30/92, effective 1/30/93.]

WAC 388-151-250 Kitchen and food service. (1) The licensee shall ensure the proper storage, preparation, and service of food to meet program needs.

(2) The licensee shall meet food service standards by ensuring;

- (a) The staff person preparing full meals has a valid food handler permit;
- (b) The staff person preparing and serving meals washes hands before handling food;
- (c) Handwashing facilities are located in or adjacent to food preparation areas;

(d) Food is stored in a sanitary manner; especially milk, shell-fish, meat, poultry, eggs, and other protein food sources;

(e) Food requiring refrigeration is stored at a temperature no warmer than forty-five degrees Fahrenheit;

(f) Frozen food is stored at a maximum temperature of zero degrees Fahrenheit;

(g) Refrigerators and freezers are equipped with thermometers and are regularly cleaned and defrosted;

(h) Food is cooked to correct temperatures;

(i) Raw food is washed thoroughly with clean running water;

(j) Cooked food to be stored is rapidly cooled and refrigerated after preparation;

(k) Food is kept in original containers or in clean, labeled containers and stored off the floor;

(l) Packaged, canned, and bottled food with a past expiration date is discarded;

(m) Food in dented cans or torn packages is discarded; and

(n) When food containing sulfiting agents is served, parents are notified.

(3) The child may participate in food preparation as an education activity when:

(a) The licensee makes kitchen equipment inaccessible to the child, except during planned and supervised kitchen activities; and

(b) Staff supervise food preparation activities.

(4) The licensee shall install and maintain kitchen equipment and clean reusable utensils in a safe and sanitary manner by:

(a) Sanitizing reusable utensils in a dishwasher or through use of a three-compartment dishwashing procedure; and

(b) Using only single-use of clean cloths, solely, for wiping food service, preparation, and eating surfaces.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-250, filed 12/30/92, effective 1/30/93.]

WAC 388-151-260 Drinking and eating equipment.

(1) The licensee shall provide the child single-use cups, individual drinking cups or glasses, or inclined jet-type drinking fountains.

(2) The licensee shall prohibit the center from using bubbler-type drinking fountains and common drinking cups or glasses.

(3) The licensee shall provide the child durable eating utensils appropriate in size and shape for the child in care.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-260, filed 12/30/92, effective 1/30/93.]

WAC 388-151-280 General safety, maintenance, and site.

(1) The licensee shall operate the center:

(a) On an environmentally safe site;

(b) In a neighborhood free from a condition detrimental to the child's welfare; and

(c) In a location accessible to health and emergency service.

(2) The licensee shall ensure that indoor and outdoor premises are in a safe and sanitary condition, free of hazards, and in good repair;

(3) The licensee shall ensure furniture and equipment is safe, stable, durable, and age-appropriate;

(4) The licensee shall maintain a flashlight or other emergency lighting device in working condition;

(5) The licensee shall finish or cover rough or untreated wood surfaces;

(6) The licensee shall maintain one or more telephones in working order, readily accessible to staff and children;

(7) The licensee shall supply bathrooms and other rooms subject to moisture with washable, moisture-impervious flooring;

(8) The licensee shall ensure staff can gain rapid access in an emergency to a bathroom or other room the child occupies;

(9) The licensee shall shield light bulbs and tubes in child-accessible areas;

(10) The licensee shall keep the premises free from rodents, fleas, cockroaches, and other insects and pests;

(11) The licensee shall ensure no firearm or other weapon is on the premises;

(12) The licensee shall maintain adequate storage space for play and teaching equipment, supplies, records, and children's possessions and clothing;

(13) The licensee shall safely store or make inaccessible to the child cleaning supplies, toxic substances, paint, poisons, aerosol containers, and items bearing warning labels;

(14) The licensee shall label a container filled from a stock supply to identify contents;

(15) The licensee shall comply with fire safety regulations adopted by the state fire marshal's office.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-280, filed 12/30/92, effective 1/30/93.]

WAC 388-151-290 Water safety. (1) The licensee shall maintain the following water safety precautions when the child uses an on-premises swimming pool, wading pool, or natural body of water, or enters the water on a field trip by ensuring;

- (a) The on-premises pool or natural body of water is inaccessible to the child when not in use;
- (b) During the child's use of a wading pool, an adult with current CPR training supervises the child at all times; and
- (c) During the child's use of a swimming pool or natural body of water, a certified lifeguard is present at all times, in addition to required staff.

(2) The licensee shall daily empty and clean portable wading pools, when in use.

(3) The licensee may permit the child to use or access a hot tub, spa tank, or whirlpool only under direct supervision and with written parental permission.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-290, filed 12/30/92, effective 1/30/93.]

WAC 388-151-310 First aid supplies. (1) The licensee shall maintain on the premises adequate first aid supplies conforming with the center's first aid policies and procedures.

(2) The licensee's first aid supplies shall include unexpired syrup of ipecac which may be administered only on the advice of the physician or poison control center.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-310, filed 12/30/92, effective 1/30/93.]

WAC 388-151-320 Outdoor play area. (1) The licensee shall provide a safe and equipped outdoor play area of sufficient size to meet the needs of the child in care:

- (a) Reachable by a safe route and method;
- (b) Promoting the child's active play, physical development, and coordination;
- (c) Free of any dangerous condition and affording safe child entry and exit; and
- (d) Adaptable to the child with special needs.

(2) The licensee shall ensure the center's activity schedule affords the child sufficient daily time to participate actively in outdoor play.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-320, filed 12/30/92, effective 1/30/93.]

WAC 388-151-330 Indoor space. (1) The school-age child care center shall have adequate, usable space indoors, ensuring children are not crowded. The licensee shall ensure a minimum of thirty-five square feet per child of usable space is available.

(2) The school age child care center shall have an identifiable space of its own during hours of operation, which may include moveable furnishings and equipment.

(3) The licensee shall arrange indoor space to encourage a variety of developmentally appropriate activities including:

- (a) Interest areas for focused activities;
- (b) Open areas for large motor activities;
- (c) Areas where children can work individually, in small groups, and in large groups; and
- (d) Private spaces where children can rest, play, and work alone or with a friend.

(1999 Ed.)

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-330, filed 12/30/92, effective 1/30/93.]

WAC 388-151-340 Toilets and handwashing sinks.

(1) The licensee shall supply handwashing sinks and toilets for the child equal to, at minimum, the number the state or local building code requires. Minimum ratios shall be as follows: Toilets: 1:100 boys, 1:35 girls, Urinals: 1:30.

(2) The licensee shall supply the child warm, running water for handwashing at a temperature range no less than eighty-five degrees Fahrenheit and no more than one hundred twenty degrees Fahrenheit.

(3) The licensee shall locate the child's handwashing facilities in or adjacent to rooms used for toileting.

(4) The licensee shall provide toileting privacy for the child.

(5) The licensee shall ensure rooms used for toileting are ventilated to the outdoors.

(6) The licensee shall provide the child with soap and individual towels or other appropriate devices for washing and drying the child's hands and face.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-340, filed 12/30/92, effective 1/30/93.]

WAC 388-151-380 Program atmosphere. (1) The licensee shall provide a cheerful environment for the child by placing visually stimulating decorations, pictures, or other attractive materials at appropriate heights for the child in care.

(2) The licensee shall maintain a safe and developmentally appropriate noise level.

(3) The licensee shall locate fixtures and provide lighting intensities promoting visibility and comfort for the child in care.

(4) The licensee shall maintain the temperature within the center at sixty-eight degrees Fahrenheit or more.

(5) The licensee shall regulate the temperature and ventilate the center for the health and comfort of the child in care.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-380, filed 12/30/92, effective 1/30/93.]

WAC 388-151-390 Discrimination prohibited. (1) The licensee shall comply with federal and state regulatory and statutory requirements, defined under chapter 49.60 RCW, regarding nondiscrimination in employment practices and client services.

(2) Consistent with state and federal laws, the licensee shall respect and facilitate all rights of the child in care.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-390, filed 12/30/92, effective 1/30/93.]

WAC 388-151-410 Special requirements regarding American Indian children. When five percent or more of the center's child enrollment consists of Indian children, the licensee shall develop social service resources and staff training programs designed to meet the special needs of such children through coordination with tribal, Indian health service, and Bureau of Indian Affairs social service staff and appropriate urban Indian and Alaskan native consultants.

[Title 388 WAC—p. 461]

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-410, filed 12/30/92, effective 1/30/93.]

WAC 388-151-420 Child abuse, neglect, and exploitation. The license and staff shall protect the child in care from child abuse, neglect, or exploitation, as required under chapter 26.44 RCW.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-420, filed 12/30/92, effective 1/30/93.]

WAC 388-151-430 Prohibited substances. (1) During operating hours or when the child is in care, the licensee, staff, and volunteers on center premises or caring for the child off-site shall not be under the influence of, consume, or possess an:

- (a) Alcoholic beverage; or
- (b) Illegal drug.

(2) The licensee shall prohibit smoking in the center and in the motor vehicle when the licensee transports the child. The licensee may permit on premises smoking outdoors, away from the building, when the child is not present.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-430, filed 12/30/92, effective 1/30/93.]

WAC 388-151-440 Limitations to persons on premises. (1) During center operating hours or while the child is in care, only the licensee, employee, or volunteer, or an authorized representative of a governmental agency, school district, or an approved adult related to the child in care shall have unsupervised access to the child in care.

(2) The licensee shall allow the parent of a child in care unsupervised access only to the parent's child.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-440, filed 12/30/92, effective 1/30/93.]

WAC 388-151-450 Child records and information. The licensee shall maintain, on the premises, organized and confidential records and information concerning the child in care. The licensee shall ensure the child's record contains, at a minimum:

(1) Registration data:

- (a) Name, birth date, dates of enrollment and termination, and other identifying information;
- (b) Name, address, and home and business telephone numbers of the parent and other person to be contacted in case of emergency; and
- (c) Completed enrollment application signed by the parent, guardian, or responsible relative.

(2) Authorizations:

- (a) Name, address, and telephone number of another person authorized to remove the child in care from the center;
- (b) Written parental consent for transportation provided by the center, including field trips and swimming, when the child participates in these activities. A parent-signed blanket consent form may authorize the child's off-site travel; and
- (c) Written parental consent, or court order, for providing medical care and emergency surgery, except for such care authorized by law.

(3) Medical and health data:

(a) Date and kind of illness or injury occurring on the premises including the treatment given by staff;

(b) Medication given by staff indicating dosage, date, time, and name of dispensing staff person; and

(c) A health history obtained when the licensee or staff enrolls the child for care. The history includes:

- (i) The date of the child's last physical examination;
- (ii) Allergies;
- (iii) Special health or developmental problems and other pertinent health information;
- (iv) Name, address, and telephone number of child's health care provider or facility; and
- (v) A record of immunization status.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-450, filed 12/30/92, effective 1/30/93.]

WAC 388-151-460 Program records. The licensee shall maintain the following documentation on the premises:

(1) The daily attendance record:

(a) The parent, or other person authorized by the parent to take the child to or from the center, shall sign in the child on arrival and shall sign out the child at departure, using a full, legal signature; and

(b) When the child leaves the center to attend school or other off-site activity as authorized by the parent, the staff person shall sign out the child and sign in the child on return to the center.

(2) A copy of the report sent to the department about the illness or injury to the child in care requiring medical treatment or hospitalization;

(3) The twelve-month record indicating the date and time the licensee conducted the required monthly fire evacuation drills;

(4) A written plan for staff development specifying the content, frequency, and manner of planned training;

(5) Activity program plan records;

(6) A list of the child's allergies and dietary restrictions;

(7) Any incident involving the use of physical restraint;

(8) A record of medication staff gives to the child; and

(9) A record of accidents and injuries.

[Statutory Authority: Chapter 74.15 RCW. 93-02-020 (Order 3493), § 388-151-460, filed 12/30/92, effective 1/30/93.]

WAC 388-151-470 Personnel policies and records.

(1) Each employee and volunteer having unsupervised or regular access to the child in care shall complete and submit to the licensee or director by the date of hire:

(a) An application for employment on a department-prescribed form or its equivalent; and

(b) A criminal history and background inquiry form:

(i) The licensee shall submit this form to the department for the employee and volunteer, within seven calendar days of the employee's first day of employment, permitting a criminal and background history check; and

(ii) The department shall discuss the inquiry information with the licensee or director, when applicable.

(2) Each employee serving as a program director, site coordinator, or staff person required to complete training under WAC 388-151-190(7) shall complete and submit to the licensee or director by the date of hire a Washington state

training and registry system (STARS) profile form. The licensee shall submit this form to the Washington state training and registry system within seven calendar days of the employee's first day of employment, permitting tracking of the employee's compliance with training requirements.

(3) The licensee shall have written personnel policies describing staff benefits, if any, duties, qualifications, grievance procedures, pay dates, and nondiscrimination policies.

(4) The licensee shall maintain a personnel record keeping system, having on file for the licensee, staff person, and volunteer:

(a) An employment application including work and education history;

(b) Documentation of criminal history and background inquiry form submission;

(c) A record of Mantoux method tuberculin skin test results, x-ray, or an exemption to the skin test or x-ray;

(d) Documentation on HIV/AIDS education and training;

(e) A record of participation in staff development training;

(f) Documentation of orientation program completion;

(g) Documentation of a valid food handler permit, when applicable;

(h) Documentation of current first aid and CPR training, when applicable; and

(i) Documentation of basic and annual training required under WAC 388-151-180 (2)(i) and (4)(f), 388-151-190(7) and 388-151-200(7).

[Statutory Authority: RCW 74.15.030, 98-24-052, § 388-151-470, filed 11/25/98, effective 12/26/98. Statutory Authority: Chapter 74.15 RCW, 93-02-020 (Order 3493), § 388-151-470, filed 12/30/92, effective 1/30/93.]

WAC 388-151-480 Reporting of death, injury, illness, epidemic, or child abuse. The licensee or staff shall report immediately:

(1) A death, serious injury requiring medical treatment, or illness requiring hospitalization of a child in care, by telephone and in writing, to the child's parent and the department;

(2) An instance when the licensee or staff has reason to suspect the occurrence of physical, sexual, or emotional child abuse, child neglect, or child exploitation as required under chapter 26.44 RCW, by telephone, to child protective services or local law enforcement; and

(3) An occurrence of food poisoning or communicable disease, as required by the state board of health, by telephone, to the local public health department.

[Statutory Authority: Chapter 74.15 RCW, 93-02-020 (Order 3493), § 388-151-480, filed 12/30/92, effective 1/30/93.]

WAC 388-151-490 Reporting of circumstantial changes. A school-age child care center license is valid only for the address, person, and organization named on the license. The licensee shall promptly report to the department a major change affecting the center's classification, delivery of safe, developmentally appropriate services, or continued eligibility for licensure. A major change includes the :

(1) Center's address, location, space, or phone number;

(2) Maximum number and ages of children served as compared to current license specifications;

(3) Change of ownership, chief executive officer, licensee, director, or site coordinator;

(4) Name of the licensed corporation or name by which the center is commonly known or changes in the center's articles of incorporation and bylaws;

(5) Occurrence of a fire, major structural change, or damage to the premises; and

(6) Plans for major remodeling of the center including planned use of space not previously department-approved.

[Statutory Authority: Chapter 74.15 RCW, 93-02-020 (Order 3493), § 388-151-490, filed 12/30/92, effective 1/30/93.]

WAC 388-151-500 Posting requirements. (1) The licensee shall post the following items, clearly visible to the parent and staff:

(a) The center's child care license issued under this chapter;

(b) A list of staff names;

(c) A typical activity schedule including operating hours;

(d) Food menus;

(e) Evacuation plans and procedures including a diagram of exiting routes; and

(f) Emergency telephone numbers, including 911 and local law enforcement, highlighted and posted by the telephone with the center's address.

(2) For the staff, the licensee shall post:

(a) Dietary restrictions for particular children; and

(b) Handwashing practices.

[Statutory Authority: Chapter 74.15 RCW, 93-02-020 (Order 3493), § 388-151-500, filed 12/30/92, effective 1/30/93.]

Chapter 388-155 WAC

MINIMUM LICENSING REQUIREMENTS FOR FAMILY CHILD DAY CARE HOMES

WAC

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WAC 388-155-005 Authority. The following rules are adopted under chapters 74.12 and 74.15 RCW.

[Statutory Authority: RCW 74.12.340, 94-13-201 (Order 3745), § 388-155-005, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030, 91-04-048 (Order 3136), § 388-155-005, filed 2/1/91, effective 3/4/91.]

WAC 388-155-010 Definitions. As used and defined under this chapter:

"Assistant" means a child care giver or child care givers employed by the licensee to supervise a child served at the home.

"Capacity" means the maximum number of children the licensee is authorized to have on the premises at a given time.

"Child" means a person seventeen years of age and under.

"Child abuse or neglect" means the injury, sexual abuse, sexual exploitation, or negligent treatment or maltreatment of a child by a person under circumstances indicating the child's health, welfare, and safety is harmed.

"Department" means the state department of social and health services.

"Department of health" means the state department of health.

"Family abode" means "a single dwelling unit and accessory buildings occupied for living purposes by a family which provides permanent provisions for living, sleeping, eating, cooking, and sanitation."

"Family child care home" means a facility in the family residence of the licensee providing regularly scheduled care for twelve or fewer children, within a birth through

eleven-years-of-age range exclusively, for periods less than twenty-four hours.

"Family child day care home" means the same as "family child care home" and "a child day care facility, licensed by the state, located in the family abode of the person or persons under whose direct care and supervision the child is placed, for the care of twelve or fewer children, including children who reside at the home."

"Family residence" means the same as "family abode."

"Home" means the same as "family child care home."

"License" means a permit issued by the department authorizing by law the licensee to operate a family child care home and certifying the licensee meets minimum requirements under licensure.

"Licensee" means the person, organization, or legal entity responsible for operating the home.

"Premises" means the buildings where the home is located and the adjoining grounds over which the licensee has control.

"Provider" means the same as "licensee."

"Under two years of age" means a child twenty-three months of age or younger.

"The Washington state training and registry system (STARS)" means the entity approved by the department to determine the classes, courses, and workshops licensees and staff may take to satisfy training requirements.

[Statutory Authority: RCW 74.15.030, 98-24-052, § 388-155-010, filed 11/25/98, effective 12/26/98; 91-04-048 (Order 3136), § 388-155-010, filed 2/1/91, effective 3/4/91.]

WAC 388-155-020 Scope of licensing. (1) The person operating a family child care home shall be subject to licensing by authority under chapter 74.15 RCW, unless exempted by RCW 74.15.020(4).

(2) The person operating a family child care home and qualifying for exemption from requirements of this chapter under RCW 74.15.020(4) shall not be subject to licensure. The person claiming an exemption shall provide the department proof of entitlement to the exemption on the department's request.

(3)(a) RCW 74.15.020 (4)(c)(i) exempts from licensing persons who care for a neighbor's or friend's child or children, with or without compensation, where:

(i) Care is provided for less than twenty-four hours; and

(ii) Such activity is not conducted on an ongoing, regularly scheduled basis for the purpose of engaging in business, which includes, but is not limited to advertising such care.

(b) For purposes of this section:

(i) "Advertising" means attempting to solicit child care clients, either directly or indirectly, through written, or electronic means;

(ii) "Engaging in business" shall exclude those persons providing child care for only one family of children or who can demonstrate that their gross earnings from child care will not exceed \$1,000 in any one calendar year;

(iii) "Friend" means someone with whom the care provider had a personal relationship prior to the time care was sought, offered, or provided;

(iv) "Neighbor" means a person with whom the care provider has relationship by virtue to living in close proximity to the person;

(v) "Ongoing" means that care is provided for a number of consecutive weeks or months or there is no specific time frame for ending child care;

(vi) "Regularly scheduled" means that the child comes at usually planned times and/or days and/or the provider makes her/himself available to provide care at fixed or planned intervals.

(4) The department shall not license the home legally exempt from licensing. However, at the applicant's request, the department shall investigate and may certify the home as meeting licensing and other pertinent requirements. In such cases, the department's requirements and procedures for licensure shall apply equally to certification.

(5) The department may certify a family day care home for payment without further investigation if the home is:

(a) Licensed by an Indian tribe; or

(b) Certified by the Federal Department of Defense.

The home must be licensed or certified in accordance with national or state standards or standards approved by the department and be operated on the premises over which the entity licensing or certifying the home has jurisdiction.

(6) The person or organization desiring to serve state-paid children shall:

(a) Be licensed or certified;

(b) Follow billing policies and procedures in *Child Day Care Subsidies, A Booklet for Providers*, DSHS 22-877(X); and

(c) Bill the department at the person's or organization's customary rate or the DSHS rate, whichever is less.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-020, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-155-020, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030. 91-15-084 (Order 3205), § 388-155-020, filed 7/23/91, effective 8/23/91; 91-04-048 (Order 3136), § 388-155-020, filed 2/1/91, effective 3/4/91.]

WAC 388-155-040 Local ordinances and codes. The department shall issue or deny a license on the basis of the applicant's compliance with minimum licensing and procedural requirements. Local officials shall be responsible for enforcing city ordinances and county codes, such as zoning and building regulations.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-040, filed 2/1/91, effective 3/4/91.]

WAC 388-155-050 Waivers. (1) In an individual case, the department, for good cause, may waive a specific requirement and may approve an alternate method of achieving the specific requirement's intent if the:

(a) Licensee or applicant submits to the department a written waiver request fully explaining the circumstances necessitating the waiver; and

(b) Department determines waiver approval will not jeopardize the safety or welfare of the child in care or detract from the quality of services the licensee delivers.

(2) The department may approve a waiver request only for a specific purpose or child and for a specific period of time not exceeding the expiration date of the license.

(3) The department may limit or restrict a license issued in conjunction with a waiver.

(4) The licensee shall maintain on the premises a copy of the written waiver approval.

(5) The department's denial of a waiver request shall not be subject to appeal under chapter 34.05 RCW.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-050, filed 2/1/91, effective 3/4/91.]

WAC 388-155-060 Dual licensure. The department shall not issue a family child care home license to the applicant having a foster family home license or other license involving full-time care or permit simultaneous care for the child and adult on the same premises. An exception may be granted if the applicant or licensee:

(1) Demonstrates evidence that care of one client category will not interfere with the quality of care provided to another category of clients;

(2) Requests and obtains a waiver permitting dual licensure;

(3) Maintains the most stringent maximum capacity limitation for the client categories concerned; and

(4) Where the licensee desires to exceed the most stringent maximum capacity limitation, requests an additional waiver to subsection (3) above. This additional waiver request may be written on one form with the request for dual licensing.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-060, filed 4/26/96, effective 5/27/96. Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-060, filed 2/1/91, effective 3/4/91.]

WAC 388-155-070 Application and reapplication for licensure—Orientation, training and investigation. (1) The person, organization, or legal entity applying for a license or re licensure under this chapter and responsible for operating the home shall:

(a) Attend orientation and training programs provided, arranged, or approved by the department;

(b) Comply with application procedures the department prescribes; and

(c) Submit to the department:

(i) A completed department-supplied application for family child care home license, including required attachments, ninety or more days before the:

(A) Beginning of licensed care;

(B) Expiration of a current license;

(C) Relocation of a home; or

(D) Change of licensed capacity category.

(ii) A completed criminal history and background inquiry form for each applicant, assistant, volunteer, or member of the household sixteen years of age or older having unsupervised or regular access to the child in care; and

(iii) The licensing fee.

(2) In addition to the required application materials specified under subsection (1) of this section, the applicant for initial licensure shall submit to the department:

(a) A department-supplied employment and education resume of the applicant and assistant including a transcript or

its equivalent documenting early childhood education class completion, where appropriate; and

(b) Three references for the applicant.

(3) The applicant for a license under this chapter shall be eighteen years of age or older.

(4) The department may, at any time, require additional information from the applicant, licensee, assistant, volunteer, member of their household and other person having access to the child in care as the department deems necessary, including, but not limited to:

- (a) Sexual deviancy evaluations;
- (b) Substance and alcohol abuse evaluations;
- (c) Psychiatric evaluations;
- (d) Psychological evaluations; and
- (e) Medical evaluations.

(5) The department may perform investigations of the applicant, licensee, assistant, volunteer, member of their household, and other person having access to the child in care as the department deems necessary, including accessing criminal histories and law enforcement files.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-070, filed 4/26/96, effective 5/27/96. Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-070, filed 2/1/91, effective 3/4/91.]

WAC 388-155-080 Issuance of license. (1) The department shall issue the applicant or licensee a license for a specific number of children dependent on the:

(a) Department's evaluation of the home's premises and physical accommodations;

(b) Number and skills of the licensee, assistant, and volunteers; and

(c) Ages and characteristics of the children served.

(2) The department:

(a) May issue the applicant or licensee a license to care for fewer children than the home's maximum capacity; and

(b) Shall not issue the applicant or licensee a license for the care of more children than permitted under this chapter.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-080, filed 2/1/91, effective 3/4/91.]

WAC 388-155-085 Initial license. (1) The department may issue an initial license to an applicant not currently licensed to provide child day care when the applicant:

(a) Can demonstrate compliance with the rules contained in this chapter pertaining to the health and safety of the child in care; but

(b) Cannot demonstrate compliance with the rules pertaining to:

- (i) Provider-child interactions,
- (ii) Capacity,
- (iii) Behavior management,
- (iv) Activity and routines,
- (v) Child records and information, and

(vi) Other rules requiring department observation of the applicant's ability to comply with rules.

(c) Can provide a plan, acceptable to the department, to comply with rules found in subsection (1)(b) of this section.

(2) The department may issue an initial license to an applicant for a period not to exceed six months, renewable for a period not to exceed two years.

(3) The department shall evaluate the applicant's ability to comply with all rules contained in this chapter during the period of initial licensure prior to issuing a full license.

(4) The department may issue a full license to the applicant demonstrating compliance with all rules contained in this chapter at any time during the period of initial licensure.

(5) The department shall not issue a full license to the applicant who does not demonstrate the ability to comply with all rules contained in this chapter during the period of initial licensure.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-085, filed 10/1/96, effective 11/1/96.]

WAC 388-155-090 License denial, suspension, or revocation. (1) Before granting a license and as a condition for continuance of a license, the department shall consider the ability of the applicant and licensee to meet the requirements of this chapter. If more than one person is the applicant or licensee, the department:

(a) Shall consider the persons' qualifications separately and jointly; and

(b) May deny, suspend, revoke, or not renew the license based on the failure of one of the persons to meet the requirements.

(2) The department shall deny, suspend, revoke, or not renew the license of a person who:

(a) Has abused, neglected, or sexually exploited a child as those acts or omissions are defined in RCW 26.44.020 and WAC 388-15-130, is ineligible to provide care because of a criminal history under chapter 388-330 WAC, or allows such a person on the premises;

(b) Commits or was convicted of a felony reasonably related to the competency of the person to meet the requirements of this chapter;

(c) Engages in illegal use of a drug or excessive use of alcohol;

(d) Commits, permits, aids, or abets the commission of an illegal act on the premises;

(e) Commits, permits, aids, or abets the abuse, neglect, exploitation, or cruel or indifferent care to a child in care;

(f) Refuses to permit an authorized representative of the department, state fire marshal, department of health, or state auditor's office to inspect the premises; or

(g) Refuses to permit an authorized representative of the department, the department of health, or the state auditor's office access to records related to operation of the home or to interview an assistant or a child in care.

(3) The department may deny, suspend, revoke, or not renew a license of a person who:

(a) Seeks to obtain or retain a license by fraudulent means or misrepresentation, including, but not limited to:

(i) Making a materially false statement on the application; or

(ii) Omitting material information on the application.

(b) Provides insufficient staff in relation to the number, ages, or characteristics of children in care;

(c) Allows a person unqualified by training, experience, or temperament to care for or be in contact with a child in care;

(d) Violates any condition or limitation on licensure including, but not limited to:

(i) Permitting more children on the premises than the number for which the home is licensed; or

(ii) Permitting on the premises a child of an age different from the ages for which the home is licensed.

(e) Fails to provide adequate supervision to a child in care;

(f) Demonstrates an inability to exercise fiscal responsibility and accountability with respect to operation of the home;

(g) Misappropriates property of a child in care;

(h) Knowingly permits on the premises an employee or volunteer who has made a material misrepresentation on an application for employment or volunteer service;

(i) Refuses or fails to supply necessary, additional department-requested information; or

(j) Fails to comply with any provision of chapter 74.15 RCW or this chapter.

(4) The department shall not issue a license to a person who has had denied, suspended, revoked, or not renewed a license to operate a facility for the care of children or adults, in this state or elsewhere, unless the person demonstrates by clear, cogent, and convincing evidence the person has undertaken sufficient corrective action or rehabilitation to warrant public trust and to operate the home in accordance with the rules of this chapter.

(5) The department's notice of a denial, revocation, suspension, or modification of a license and the applicant's or licensee's right to a hearing shall be governed under RCW 43.20A.205.

[Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-155-090, filed 4/26/96, effective 5/27/96. Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-155-090, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-090, filed 2/1/91, effective 3/4/91.]

WAC 388-155-092 Civil penalties. (1) Before imposing a civil penalty, the department shall provide written notification by personal service, including by the licensor, or certified mail which shall include:

(a) A description of the violation and citation of the applicable requirement or law;

(b) A statement of what is required to achieve compliance;

(c) The date by which the department requires compliance;

(d) The maximum allowable penalty if timely compliance is not achieved;

(e) The means to contact any technical assistance services provided by the department or others; and

(f) Notice of when, where, and to whom a request to extend the time to achieve compliance for good cause may be filed with the department.

(2) The length of time in which to comply shall depend on:

(a) The seriousness of the violation;

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(b) The potential threat to the health, safety and welfare of children in care; or

(c) Previous opportunities to correct the deficiency.

(3) The department may impose a civil penalty based on but not limited to these reasons:

(a) The child care home has previously been subject to an enforcement action for the same or similar type of violation of the same statute or rule; or

(b) The child care home has previously been given notice of the same or similar type of violation of the same statute or rule; or

(c) The violation represents a potential threat to the health, safety, and/or welfare of children in care.

(4) The department may impose a civil penalty in addition to or in conjunction with other disciplinary actions against a child care license including probation, suspension, or other action.

(5) The civil fine shall be payable twenty-eight days after receipt of the notice or later as specified by the department.

(6) The fine may be forgiven if the agency comes into compliance during the notification period.

(7) The center or person against whom the department assesses a civil fine has a right to an adjudicative proceeding as governed by RCW 43.20A.215.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-092, filed 10/1/96, effective 11/1/96.]

WAC 388-155-093 Civil penalties—Amount of penalty. Whenever the department imposes a civil monetary penalty per WAC 388-155-092(3), the department shall impose a penalty of seventy-five dollars per violation per day. The department may assess and collect the penalty with interest for each day of noncompliance.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-093, filed 10/1/96, effective 11/1/96.]

WAC 388-155-094 Civil penalty—Posting of notice of penalty. (1) The licensee shall post the final notice of a civil penalty in a conspicuous place in the facility.

(2) The notice shall remain posted until payment is received by the department.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-094, filed 10/1/96, effective 11/1/96.]

WAC 388-155-095 Civil penalties—Unlicensed programs. Where the department has determined that an agency is operating without a license, the department shall send written notification by certified mail or other means showing proof of service. This notification shall contain the following:

(1) Advising the agency of the basis of determination of providing child care without a license and the need to be licensed by the department;

(2) The citation of the applicable law;

(3) The assessment of seventy-five dollars per day penalty for each day unlicensed care is provided. The fine would be effective and payable within thirty days of receipt of the notification;

(4) How to contact the office of child care policy;

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(5) The need to submit an application to the office of child care policy within thirty days of receipt of the notification;

(6) That the penalty may be forgiven if the agency submits an application within thirty days of the notification; and

(7) The right of an adjudicative proceeding as a result of the assessment of a monetary penalty and the appropriate procedure for requesting an adjudicative proceeding.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-095, filed 10/1/96, effective 11/1/96.]

WAC 388-155-096 Civil penalties—Separate violations. Each violation of a law or rule constitutes a separate violation and may be penalized as such.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-096, filed 10/1/96, effective 11/1/96.]

WAC 388-155-097 Civil penalties—Penalty for non-payment. The department may suspend, revoke or not renew a license for failure to pay a civil monetary penalty it has assessed within ten days after such assessment becomes final.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-097, filed 10/1/96, effective 11/1/96.]

WAC 388-155-098 Probationary license. (1) The department shall base the decision as to whether a probationary license will be issued upon the following factors:

- (a) Willful or negligent noncompliance by the licensee,
- (b) History of noncompliance,
- (c) Extent of deviation from the requirements,
- (d) Evidence of a good faith effort to comply,
- (e) Any other factors relevant to the unique situation.

(2) Where the negligent or willful violation of the licensing requirements does not present an immediate threat to the health and well-being of the children but would be likely to do so if allowed to continue, a probationary license may be issued as well as civil penalties or other sanctions. Such situations may include:

(a) Substantiation that a child (or children) was abused or neglected while in the care of the center,

- (b) Disapproved fire safety or sanitation report,
- (c) Use of unauthorized space for child care,
- (d) Inadequate supervision of children,
- (e) Understaffing for the number of children in care,
- (f) Noncompliance with requirements addressing:
 - (i) Children's health,
 - (ii) Proper nutrition,
 - (iii) Discipline,
 - (iv) Emergency medical plan,
 - (v) Sanitation and personal hygiene practices.

(3) Licensee required to notify parents when a probationary licensed is issued:

(a) The licensee shall notify the parents or guardians of all children in care that it is in probationary status within five working days of receiving notification he or she has been issued a probationary license;

(b) The notification shall be in writing and shall be approved by the department prior to being sent;

(c) The licensee shall provide documentation to the department that parents or guardians of all children in care

have been notified within ten working days of receiving notification that he or she has been issued a probationary license;

(d) The department may issue a probationary license for up to six months, and at the discretion of the department it may be extended for an additional six months.

[Statutory Authority: RCW 74.15.030. 96-20-095, § 388-155-098, filed 10/1/96, effective 11/1/96.]

WAC 388-155-100 Activities and routines. (1) The provider shall offer activities and routines designed to meet the developmental, cultural, and individual needs of the child served. The provider shall ensure the activities and routines contain a range of learning experiences for the child to:

- (a) Gain self-esteem, self-awareness, self-control, and decision-making abilities;
- (b) Develop socially, emotionally, intellectually, and physically;
- (c) Learn about nutrition, health, and personal safety; and
- (d) Experiment, create, and explore.

(2) The provider shall implement a schedule of daily activities, establishing familiar routines and contributing to learning experiences, with allowances for a variety of special events.

(3) The provider shall ensure the home's activities offer variety and options, including a balance between:

- (a) Child-initiated and provider-initiated activities;
- (b) Free play and organized events;
- (c) Individual and group activities; and
- (d) Quiet and active experiences.

(4) The provider shall ensure the home's daily routine affords the child opportunities for small and large muscle activities and outdoor play.

(5) The child may remain in care only ten hours or less per day except as necessitated by the parent's working hours and travel time from and to the home.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-100, filed 2/1/91, effective 3/4/91.]

WAC 388-155-110 Learning and play materials. The provider shall furnish the child a variety of easily accessible, developmentally appropriate learning and play materials of sufficient quantity to implement the home's daily activities. The provider shall ensure material is culturally relevant and promotes:

- (1) Social development;
- (2) Intellectual ability;
- (3) Language development and communication;
- (4) Self-help skills;
- (5) Sensory stimulation;
- (6) Large and small muscle development; and
- (7) Creative expression.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-110, filed 2/1/91, effective 3/4/91.]

WAC 388-155-120 Provider-child interactions. (1) The provider shall furnish the child a nurturing, respectful, supportive, and responsive environment through frequent interactions with the child:

(a) Supporting the child in developing an understanding of self and others by assisting the child to share ideas, experiences, and feelings;

(b) Providing age-appropriate opportunities for intellectual growth and development of the child's social and language skills, including encouraging the child to ask questions;

(c) Helping the child solve problems;

(d) Fostering creativity and independence in routine activities, including showing tolerance for mistakes; and

(e) Treating equally children in care regardless of race, religion, and handicapping condition.

(2) The provider shall:

(a) Furnish the child a pleasant and educational environment at meal and snack times; and

(b) Provide good models for nutrition habits and social behavior by:

(i) Eating with children, when feasible; and

(ii) Encouraging conversation among children.

(3) The provider shall ensure the child is supervised by continuous visual or auditory contact.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-120, filed 2/1/91, effective 3/4/91.]

WAC 388-155-130 Behavior management and discipline. (1) The licensee shall guide the child's behavior based on an understanding of the individual child's needs and stage of development. The licensee shall promote the child's developmentally appropriate social behavior, self-control, and respect for the rights of others.

(2) The licensee shall ensure behavior management and discipline practices are fair, reasonable, consistent, and related to the child's behavior. The licensee shall not administer cruel, unusual, hazardous, frightening, or humiliating discipline.

(3) The licensee shall be responsible for implementing the behavior management and discipline practices of the home. The child in care shall not determine or administer behavior management or discipline.

(4) The licensee shall prohibit and prevent:

(a) Corporal punishment by any person on the premises, including hitting, biting, jerking, shaking, spanking, slapping, striking, or kicking the child, or other means of inflicting physical pain or causing bodily harm;

(b) The use of a physical restraint method injurious to the child;

(c) The use of a mechanical restraint for disciplinary purposes, locked time-out room, or closet; or

(d) The withholding of food as a punishment.

(5) In emergency situations, the licensee competent to use restraint methods may use limited physical restraint when:

(a) Protecting a person on the premises from physical injury;

(b) Obtaining possession of a weapon or other dangerous object; or

(c) Protecting property from serious damage.

(6) The licensee shall document any incident involving the use of physical restraint.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-130, filed 2/1/91, effective 3/4/91.]

WAC 388-155-140 Rest periods. (1) The provider shall offer a supervised rest period to the child:

(a) Five years of age and under remaining in care more than six hours; or

(b) Showing a need for rest.

(2) The provider shall plan quiet activities for the child not needing rest.

(3) The provider shall allow the child twenty-nine months of age and under to follow an individual sleep schedule.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-140, filed 2/1/91, effective 3/4/91.]

WAC 388-155-150 Evening and nighttime care. (1) For the home offering child care during evening and nighttime hours, the licensee shall adapt the activities, routines, and equipment to meet the physical and emotional needs of the child away from home at night.

(2) The licensee shall maintain the same capacity requirements in effect during daytime care. At all times, including sleeping hours, the child shall be within continuous visual or auditory range of the licensee or assistant.

(3) The licensee shall arrange child grouping so the sleeping child remains asleep during the arrival or departure of another child.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-150, filed 2/1/91, effective 3/4/91.]

WAC 388-155-160 Off-site trips. (1) The licensee may transport or permit the off-site travel of the child to attend school, participate in field trips, or engage in other off-site activities only with written parental consent.

(2) The parent's consent may be:

(a) For a specific date and trip; or

(b) A blanket authorization describing the full range of trips the child may take. In such case, the licensee shall notify the parent in advance about the trip.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-160, filed 2/1/91, effective 3/4/91.]

WAC 388-155-165 Transportation. When the licensee provides transportation for the child in care:

(1) The licensee shall ensure the motor vehicle is maintained in a safe operating condition;

(2) The licensee shall ensure the motor vehicle is equipped with appropriate safety devices and individual seat belts or safety seats for each child to use when the vehicle is in motion. An individual safety seat is required for the child eleven months of age and younger;

(3) The licensee shall ensure the number of passengers does not exceed the seating capacity of the motor vehicle;

(4) The licensee or driver shall carry motor vehicle liability and medical insurance. The driver shall have a current Washington driver's license, valid for the classification of motor vehicle operated;

(5) The licensee or assistant supervising the child in the motor vehicle shall have current first aid and cardiopulmonary resuscitation training; and

(6) The licensee, assistant, or driver shall not leave the child unattended in the motor vehicle.

(7) The licensee shall ensure the assistant is present in the motor vehicle when capacity guidelines require an assistant.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-165, filed 2/1/91, effective 3/4/91.]

WAC 388-155-170 Parent communication. (1) The licensee shall:

(a) Explain to the parent the provider's policies and procedures;

(b) Orient the parent to the home and activities;

(c) Advise the parent of the child's progress and issues relating to the child's care and individual practices concerning a child's special needs; and

(d) Encourage parent participation in the home's activities.

(2) The licensee shall give the parent the following written policy and procedure information:

(a) Enrollment and admission requirements;

(b) The fee and payment plan;

(c) A typical activity schedule, including hours of operation;

(d) Meals and snacks served, including guidelines on food brought from the child's home;

(e) Permission for free access by the child's parent to all home areas used by the child;

(f) Child abuse reporting requirements;

(g) Behavior management and discipline;

(h) Nondiscrimination statement;

(i) Religious activities, if any;

(j) Transportation and field trip arrangements;

(k) Medical emergencies;

(l) Practices concerning an ill child;

(m) Medication management; and

(n) If licensed for the care of the young child;

(i) Diapering;

(ii) Toilet training; and

(iii) Feeding.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-170, filed 2/1/91, effective 3/4/91.]

WAC 388-155-180 Staffing—Qualifications. (1) General qualifications. The licensee, assistant, volunteer, and other person associated with the operation of the home who has access to the child in care shall:

(a) Be of good character;

(b) Have the understanding, ability, personality, emotional stability, and physical health suited to meet the cultural emotional, mental, physical, and social needs of the child in care; and

(c) Not have committed or been convicted of child abuse or any crime involving physical harm to another person.

(2) The licensee shall:

(a) Be eighteen years of age or older;

(b) Be the primary child care provider;

(c) Ensure compliance with minimum licensing requirements under this chapter; and

(d) Have completed one of the following prior to or within the first six months of initial licensure except as provided in (e) of this subsection:

(i) Twenty clock hours or two college quarter credits of basic training approved by the Washington state training and registry system (STARS); or

(ii) Current child development associate (CDA) or equivalent credential or twelve or more college quarter credits in early childhood education or child development; or

(iii) Associate of arts or AAS or higher college degree in early childhood education, child development, school age care, elementary education or special education.

(e) Licensees already licensed on the effective date of this rule must complete the training required in WAC 388-150-180 (2)(d) prior to or within twelve months after the effective date of this rule.

(3) The assistant shall be:

(a) Fourteen years of age or older; or

(b) Eighteen years of age or older if assigned sole responsibility for the child in care; and

(c) Competent to exercise appropriate judgements.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-155-180, filed 11/25/98, effective 12/26/98; 91-04-048 (Order 3136), § 388-155-180, filed 2/1/91, effective 3/4/91.]

WAC 388-155-190 Capacity. (1) The department shall determine the maximum capacity of the family child care home based on the:

(a) Licensee's experience and training;

(b) Assistant's qualifications;

(c) Number, ages, and characteristics of the children cared for;

(d) Number and ages of the licensee's own children and other children residing in the home eleven years of age and under;

(e) Usable indoor and outdoor space; and

(f) Supply of toys and equipment.

(2) The department may license the family child care home according to the following table:

NUMBER OF PROVIDERS REQUIRED	AGE RANGE IN YEARS	MAXIMUM NUMBER OF CHILDREN UNDER TWO YEARS OF AGE	MAXIMUM NUMBER OF CHILDREN
(a) Licensee	Birth - 11	2	6
(b) Licensee with one year experience	2 - 11	None	8
(c) Licensee with one year experience	5 - 11	None	10

NUMBER OF PROVIDERS REQUIRED	AGE RANGE IN YEARS	MAXIMUM NUMBER OF CHILDREN UNDER TWO YEARS OF AGE	MAXIMUM NUMBER OF CHILDREN
(d) Licensee with one year experience plus assistant	Birth - 11	4	9
(e) Licensee with two years' experience and one early childhood education (ECE) class	3 - 11	None	10
(f) Licensee with two years' experience and one ECE class plus assistant	Birth - 11	4	12

So that the:

(a) Unassisted licensee may provide care for a maximum of six children, birth through eleven years of age, with two or fewer children under two years of age; or

(b) Unassisted licensee with one year of experience operating a licensed family child care home or the equivalent experience may provide care for a maximum of eight children, two years through eleven years of age; or

(c) Unassisted licensee with one year of experience operating a licensed family child care home or the equivalent experience may provide care for a maximum of ten children, five years through eleven years of age; or

(d) Licensee with one year of experience as a licensed family child care home provider or the equivalent experience and an assistant may provide care for seven through nine children, birth through eleven years of age, with four or fewer children under two years of age; or

(e) Unassisted licensee with two years of experience operating a licensed family child care home or the equivalent experience and one class in ECE, or the equivalent education, may provide care for a maximum of ten children, three years through eleven years of age; or

(f) Licensee with two years of experience operating a licensed family child care home or the equivalent experience, one class in ECE or the equivalent education, and a qualified assistant may provide care for a maximum of twelve children, birth through eleven years of age, with four or fewer children under two years of age.

(3) The licensee shall ensure an assistant is on the premises when:

(a) Three or more children under two years of age are in care;

(b) Seven or more children are in care and any child in care is under two years of age; or

(c) More than ten children are in care.

(4) The department's determination of capacity shall include all children eleven years of age or under on the premises.

(5) The licensee shall ensure the assistant is eighteen years of age or older when the assistant is solely responsible for the child in care.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-190, filed 2/1/91, effective 3/4/91.]

WAC 388-155-200 Development and training. (1) The licensee shall have an orientation system making the new employee and volunteer aware of policies and practices. The licensee shall provide the new employee or volunteer an orientation including, but not limited to:

- (a) Minimum licensing rules required under this chapter;
- (b) Goals and philosophy of the home;
- (c) Daily activities and routines;
- (d) Child guidance and behavior management methods;
- (e) Child abuse and neglect prevention, detection, and reporting policies and procedures;
- (f) Special health and developmental needs of the individual child;
- (g) The health care plan;
- (h) Fire prevention and safety procedures; and
- (i) Personnel policies, when applicable.

(2) The licensee shall:

(a) Obtain basic, standard first aid, and cardiopulmonary resuscitation (CPR) training, approved by the department of health. CPR training shall include methods appropriate for child age groups in care;

(b) Ensure that first aid and CPR training is current; and

(c) Annually, beginning one year after licensure, complete ten clock hours or one college quarter credit of training. Training must be approved by the Washington state training and registry system (STARS). For those already licensed on the effective date of this rule, this requirement for annual training shall begin one year after the effective date of this rule.

(3) The licensee shall ensure the assistant eighteen years of age or older obtains basic, standard first aid, and CPR training approved by the department of health if the assistant will be solely responsible for the child in care.

(4) The licensee and assistant shall obtain appropriate education and training on the prevention and transmission of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

(5) The licensee shall encourage the assistant to participate in training opportunities to promote ongoing education and enhance practice skills.

(6) The licensee shall conduct periodic meetings for planning and coordination purposes when applicable.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-155-200, filed 11/25/98, effective 12/26/98; 91-04-048 (Order 3136), § 388-155-200, filed 2/1/91, effective 3/4/91.]

WAC 388-155-210 Health care plan. (1) The licensee shall write and implement health policies and procedures. The licensee shall make the health care plan available to:

(a) The assistant, new employee or volunteer for training and use; and

(b) The parent of the child in care, upon request.

(2) The licensee's health care plan shall include, but not be limited to, information about the home's general health practices concerning:

- (a) Injury prevention;
- (b) Treatment of illnesses;
- (c) Medication management;
- (d) Cleaning and disinfecting;
- (e) First aid, including medical emergencies;
- (f) Communicable disease prevention, management, and reporting;
- (g) Handwashing practices;
- (h) Food and food services; and
- (i) Care of the young child, where applicable.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-210, filed 2/1/91, effective 3/4/91.]

WAC 388-155-220 Health supervision and infectious disease prevention. (1) Child. The licensee shall encourage the parent to arrange a physical examination for the child who has not had regular health care or a physical examination within one year before enrollment.

(2) The licensee shall encourage the parent to obtain health care for the child when necessary. The licensee shall not be responsible for providing or paying for the child's health care.

(3) Before or on the child's first day of attendance, the parent shall present a certificate of immunization status form prescribed by the department of health proving the child's full immunization for:

- (a) Diphtheria;
- (b) Tetanus;
- (c) Pertussis (whooping cough);
- (d) Poliomyelitis;
- (e) Measles (rubeola);
- (f) Rubella (German measles);
- (g) Mumps; and

(h) Other diseases prescribed by the department of health.

(4) The licensee may accept the child without all required immunizations on a conditional basis if immunizations are:

- (a) Initiated before or on enrollment; and
- (b) Completed as rapidly as medically possible.

(5) The licensee may exempt the immunization requirement for the child if the parent or guardian:

- (a) Signs a statement expressing a religious, philosophical, or personal objection; or
- (b) Furnishes a physician's statement of a valid medical reason for the exemption.

(6) Procedures. The licensee shall daily observe the child for signs of illness. The licensee shall care for or discharge home the ill child based on the home's policies concerning an ill child.

(a) When the child has a severe illness or is injured, tired, or upset, the licensee shall separate the child from other children and attend the child continuously until:

- (i) The licensee secures appropriate health care for the child; or
- (ii) The licensee makes an arrangement to return the child to the parent; or

(iii) The child is able to rejoin the group.

(b) The licensee shall provide a quiet, separate care room or area allowing the child requiring separate care an opportunity to rest.

(c) The licensee shall sanitize equipment used by the child, if the licensee suspects the child has a communicable disease.

(d) The licensee may use the separate care room or area for other purposes when not needed for separation of the child.

(7) The licensee shall wash, or assist the child to wash hands according to the home's handwashing procedures.

(8) The licensee shall clean and disinfect toys, equipment, furnishings, and facilities according to the home's cleaning and disinfecting policies.

(9) The licensee shall have appropriate extra clothing available for the child who wets or soils clothes.

(10) The licensee shall ensure the child does not share personal hygiene or grooming items.

(11) Each licensee, assistant, volunteer, and adult member of the household having regular contact with the child in care shall have a tuberculin (TB) skin test, by the Mantoux method, upon employment or initial licensure, unless against medical advice.

(a) The person whose TB skin test is positive (ten millimeters or more induration) shall have a chest x-ray within thirty days following the skin test.

(b) The licensee shall not require the person to obtain routine periodic TB retesting or x-ray (biennial or otherwise) after entry testing unless directed to obtain retesting by the person's health care provider or the local health department.

(12) The licensee shall not permit the person with a reportable communicable disease to be on duty in the home or have contact with the child in care unless approved by a health care provider.

(13) The licensee and assistant shall wash hands according to the home's handwashing practices.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-220, filed 2/1/91, effective 3/4/91.]

WAC 388-155-230 Medication management. (1) The home may have a policy of not giving medication to the child in care.

(2) If the home's health care plan includes giving medication to the child in care, the licensee:

- (a) Shall give medications, prescription and nonprescription, only on the written approval of a parent, person, or agency having authority by court order to approve medical care;

(b) Shall give prescription medications:

- (i) Only as specified on the prescription label; or

- (ii) As authorized by a physician or other person legally authorized to prescribe medication.

- (c) Shall give the following classifications of nonprescription medications, with written parent authorization, only at the dose, duration, and method of administration specified on the manufacturer's label for the age or weight of the child needing the medication:

- (i) Antihistamines;

- (ii) Nonaspirin fever reducers/pain relievers;

- (iii) Nonnarcotic cough suppressants;
- (iv) Decongestants;
- (v) Anti-itching ointments or lotions, intended specifically to relieve itching;
- (vi) Diaper ointments and powders, intended specifically for use in the diaper area of the child; and
- (vii) Sun screen.
- (d) Shall give other nonprescription medication:
 - (i) Not included in the categories listed in subsection (2)(c) of this section; or
 - (ii) Taken differently than indicated on the manufacturer's label; or
 - (iii) Lacking labeled instructions, only when disbursement of the nonprescription medication is as required under subsection (2) (d) (i) and (ii):
 - (A) Authorized, in writing, by a physician; or
 - (B) Based on established medical policy approved, in writing, by a physician or other person legally authorized to prescribe medication.
 - (e) Shall accept from the child's parent, guardian, or responsible relative only medicine in the original container, labeled with:
 - (i) The child's first and last names;
 - (ii) The date the prescription was filled; or
 - (iii) The medication's expiration date; and
 - (iv) Legible instructions for administration, such as manufacturer's instructions or prescription label.
 - (f) Shall keep medication, refrigerated or nonrefrigerated, in an orderly fashion, inaccessible to the child;
 - (g) Shall store external medication in a compartment separate from internal medication;
 - (h) Shall keep a record of medication disbursed;
 - (i) Shall return to the parent or other responsible party, or shall dispose of medications no longer being taken; and
 - (j) May at the licensee's option, permit self-administration of medication by a child in care if the:
 - (i) Child is physically and mentally capable of properly taking medication without assistance;
 - (ii) Licensee includes in the child's file a parental or physician's written statement of the child's capacity to take medication without assistance; and
 - (iii) Licensee ensures the child's medications and other medical supplies are stored so the medications and medical supplies are inaccessible to another child in care.

[Statutory Authority: RCW 74.15.030, 91-04-048 (Order 3136), § 388-155-230, filed 2/1/91, effective 3/4/91.]

WAC 388-155-240 Nutrition. (1) The licensee shall provide food meeting the nutritional needs of the child in care, taking into consideration the:

- (a) Number of children in care;
- (b) Child's age and developmental level;
- (c) Child's cultural background;
- (d) Child's handicapping condition; and
- (e) Hours of care on the premises.

(2) The licensee shall provide only pasteurized milk or a pasteurized milk product.

(3) The licensee shall provide only whole milk to the child twenty-three months of age or under except with the written permission of the child's parent.

(1999 Ed.)

(4) The licensee may serve the child twenty-four months of age or older powdered Grade A milk mixed in the home provided the licensee completes the dry milk mixture, service, and storage in a safe and sanitary manner.

(5) The licensee may provide the child nutrient concentrates, nutrient supplements, a modified diet, or an allergy diet only with written permission of the child's health care provider. The licensee shall obtain from the parent or child's health care provider a written list of foods the child cannot consume.

(6) The licensee shall use the following meal pattern to provide food to the child in care in age-appropriate servings:

- (a) Providing the child in care for ten or less hours:
 - (i) Two or more snacks and one meal; or
 - (ii) Two meals and one snack.
- (b) Providing the child in care for ten or more hours:
 - (i) Two or more meals and two snacks; or
 - (ii) One meal and three snacks;
 - (c) Providing the child arriving after school a snack;
 - (d) Providing the child with food at not less than two-hour intervals, and not more than three and one-half hours apart; and
 - (e) Allowing the occasional serving of party foods not meeting nutritional requirements.

(7) The licensee shall provide the child in care food which complies with the meal pattern of the United States Department of Agriculture Child and Adult Care Food Program, with the addition of:

- (a) A minimum of one serving of Vitamin C fruit, vegetable, or juice, provided daily; and
- (b) Servings of food high in Vitamin A, provided three or more times weekly.
- (8) The licensee shall provide:
 - (a) Dinner to the child in evening care when the child did not receive dinner at home before arriving;
 - (b) A bedtime snack to the child in nighttime care; and
 - (c) Breakfast to the child in nighttime care if the child remains at the home after the child's usual breakfast time.

(9) The licensee shall monitor foods brought from the child's home for consumption by the child, all children, or a group of children in care ensuring safe storage and nutritional adequacy.

(10) For the home permitting sack lunches, the licensee shall have available food supplies to supplement food deficient in meeting nutrition requirements brought from the child's home and to nourish the child arriving without food.

[Statutory Authority: RCW 74.15.030, 91-04-048 (Order 3136), § 388-155-240, filed 2/1/91, effective 3/4/91.]

WAC 388-155-250 Kitchen and food service. (1) The licensee shall provide equipment for the proper storage, preparation, and service of food.

(2) The licensee shall make potentially hazardous appliances and sharp or pointed utensils inaccessible to the child when the child is not under direct supervision.

(3) The child may participate in food preparation as an educational activity.

(4) The licensee shall install and maintain kitchen equipment and clean reusable utensils in a safe and sanitary manner by:

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(a) Washing and sanitizing reusable utensils in a dishwasher or through use of a manual dishwashing procedure; and

(b) Using only single-use or clean cloths, used solely for wiping food service, preparation, and eating surfaces.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-250, filed 2/1/91, effective 3/4/91.]

WAC 388-155-260 Drinking and eating equipment.

(1) The licensee shall provide the child individual drinking cups, glasses, or disposable single-use cups.

(2) The licensee shall provide the child durable eating utensils appropriate in size and shape for the child in care.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-260, filed 2/1/91, effective 3/4/91.]

WAC 388-155-270 Care of young children. (1) Diapering and toileting. The licensee shall ensure:

(a) The diaper-changing area is:

- (i) Separate from food preparation areas; and
- (ii) Easily accessible to a handwashing sink;
- (iii) Sanitized between use for different children; or
- (iv) Protected by a disposable covering discarded after each use.

(b) The diaper-changing area is impervious to moisture and washable.

(2) The licensee shall:

(a) Use reusable diapers, a commercial diaper service, or disposable diapers;

(b) Place soiled diapers without rinsing into a separate, cleanable, covered container provided with a waterproof liner before transporting to a laundry, parent, or acceptable disposal;

(c) Remove soiled diapers from the home daily or more often unless the licensee uses a commercial diaper service;

(d) Use disposable towels or clean, reusable towels laundered between use for different children for cleaning the child; and

(e) Wash hands after diapering the child or helping the child with toileting.

(3) The licensee shall:

(a) Consult with the child's parent regarding initiating toilet training;

(b) Locate potty chairs on washable, impervious surfaces when in use; and

(c) Sanitize toilet training equipment after each use.

(4) Feeding. The licensee and the infant's parent shall agree on a schedule for feedings:

(a) The licensee or parent may provide the child's bottle feeding in the following manner:

- (i) A filled bottle brought from home;
- (ii) Whole milk or formula in ready-to-feed strength; or
- (iii) Formula requiring no preparation other than dilution with water, mixed on the premises.

(b) The licensee shall prepare the child's bottle and nipple in a sanitary manner in an area separate from the diapering area.

(c) The licensee shall sanitize the child's bottle and nipple between uses.

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(d) The licensee shall label the bottle with the child's name and date prepared, if more than one bottle-fed child is in care.

(e) The licensee shall refrigerate a filled bottle if the child does not consume the contents immediately and discard the bottle's contents if the child does not consume the contents within twelve hours.

(f) To ensure safety and promote nurturing, the licensee and assistant shall:

(i) Hold in a semi-sitting position for feeding the child unable to sit in a high chair, unless such is against medical advice;

(ii) Interact with the child;

(iii) Not prop a bottle;

(iv) Not give a bottle to the reclining child; and

(v) Take the bottle from the child when the child finishes feeding.

(g) The licensee shall provide semi-solid food for the child, upon consultation with the parent, as recommended by the child's health care provider.

(5) Sleeping equipment. The licensee shall furnish the child a single-level crib, infant bed, bassinet, or play pen for napping until such time the parent and licensee agree the child can safely use a mat, cot, or other approved sleep equipment.

(6) The licensee shall ensure the young child has a sturdy crib, infant bed, bassinet, or play pen:

(a) Made of wood, metal, or plastic with secure latching devices; and

(b) Constructed with two and three-eighths inches or less space between vertical slats when the crib is used for a child six months of age or younger; and

(c) Additionally supplied with crib bumpers or another effective method preventing the child's body from slipping between the slats.

(7) The licensee shall ensure the child's crib mattress, infant bed, bassinet, or play pen mattress is:

(a) Snug fitting, preventing the infant from being caught between the mattress and crib side rails; and

(b) Waterproof and easily sanitized.

(8) Activities and equipment. The licensee shall provide the young child a daily opportunity for:

(a) Large and small muscle development;

(b) Crawling and exploring;

(c) Sensory stimulation;

(d) Social interaction;

(e) Development of communication; and

(f) Learning self-help skills.

(9) The licensee shall provide the young child safe, non-ingestible, suitable toys and equipment for the child's mental and physical development.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-270, filed 2/1/91, effective 3/4/91.]

WAC 388-155-280 General safety, maintenance, and site. (1) The licensee shall operate the home on an environmentally safe site.

(2) The licensee shall maintain the indoor and outdoor premises in a safe and sanitary condition, free of hazards, and in good repair. The licensee shall ensure furniture and equip-

ment are safe, stable, durable, and free of sharp, loose, or pointed parts.

(3) The licensee shall:

(a) Install handrails or safety devices at child height adjacent to steps, stairways, and ramps;

(b) Maintain a flashlight or other emergency lighting device in working condition;

(c) Ensure there is no flaking or deteriorating lead-based paint on interior and exterior surfaces, equipment, and toys accessible to the child;

(d) Finish rough or untreated wood surfaces; and

(e) Maintain one or more telephones in working order.

(4) The licensee shall supply bathrooms and other rooms subject to moisture with washable, moisture-impervious flooring or routinely cleaned floor covering.

(5) The licensee shall equip child-accessible electrical outlets with nonremovable safety devices or covers preventing electrical injury.

(6) The licensee shall ensure staff can gain rapid access in an emergency to a bathroom or other room occupied by the child.

(7) The licensee shall keep the premises free from rodents, fleas, cockroaches, and other insects and pests.

(8) The licensee shall use an appropriate method for drawing clean mop water and disposing waste water.

(9) The licensee shall ensure a firearm or another weapon is kept in locked storage accessible only to an authorized person.

(10) The licensee shall ensure a person with current first aid and infant-child CPR training is on the premises at all times.

(11) The licensee shall store and make inaccessible to the child cleaning supplies, toxic substances, paint, poisons, aerosol containers, and items bearing warning labels.

(12) The licensee shall label a container filled from a stock supply to identify contents.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-280, filed 2/1/91, effective 3/4/91.]

WAC 388-155-290 Water supply, sewage, and liquid wastes. (1) The licensee shall obtain approval of a private water supply by the local health authority or department.

(2) The licensee shall ensure sewage and liquid wastes are discharged into:

(a) A public sewer system; or

(b) An independent sewage system approved by the local health authority or department.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-290, filed 2/1/91, effective 3/4/91.]

WAC 388-155-295 Water safety. (1) The licensee shall maintain the following water safety precautions when the child uses an on-premises swimming pool or wading pool. The licensee shall ensure:

(a) The on-premises pool is inaccessible to the child when not in use; and

(b) During the child's use of a wading pool or swimming pool, an adult with current CPR training supervises the child at all times.

(1999 Ed.)

(2) The licensee shall ensure a certified lifeguard is present during the child's use of an off-premises swimming pool.

(3) The licensee shall daily empty and clean a portable wading pool, when in use.

(4) The licensee shall not permit the child to use or access a heated tub, spa, whirlpool, tank, or similar equipment.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-295, filed 2/1/91, effective 3/4/91.]

WAC 388-155-310 First-aid supplies. (1) The licensee shall maintain first-aid supplies on the premises conforming with the home's first-aid policies and procedures.

(2) The home's first-aid supplies shall include unexpired syrup of ipecac which may be administered only on the advice of a physician or poison control center.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-310, filed 2/1/91, effective 3/4/91.]

WAC 388-155-320 Outdoor play area. (1) The licensee shall provide a safe and securely-fenced or department-approved, enclosed outdoor play area:

(a) Adjoining directly the indoor premises; or

(b) Reachable by a safe route and method; and

(c) Promoting the child's active play, physical development, and coordination; and

(d) Protecting the play area from unsupervised exit by the child; and

(e) Preventing child access to roadways and other dangers.

(2) The licensee shall ensure the home's activity schedule affords the child sufficient daily time to participate actively in outdoor play.

(3) The licensee shall provide a variety of age appropriate play equipment for climbing, pulling, pushing, riding, and balancing activities. The licensee shall arrange, design, construct, and maintain equipment and ground cover to prevent the child's injury. The licensee's quantity of outdoor play equipment shall offer the child a range of outdoor play options.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-320, filed 2/1/91, effective 3/4/91.]

WAC 388-155-330 Indoor play area. (1) The home's indoor premises shall contain adequate space for child play and sufficient space to house developmentally appropriate activities for the number and age range of children served. The licensee shall provide a minimum of thirty-five square feet of usable floor space per child, exclusive of a bathroom, hallway, and closet.

(2) The licensee may use and consider the napping area as child care space if mats and cots are removed when not in use. The licensee may consider the kitchen usable space if:

(a) Appliances and utensils do not create a safety hazard;

(b) Toxic or harmful substances are not accessible to the child;

(c) Food preparation and storage sanitation is maintained; and

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(d) The space is used safely and appropriately as a child care activity area.

(3) The licensee may use a room for multiple purposes such as playing, dining, napping, and learning activities, provided:

(a) The room is of sufficient size; and

(b) The room's use for one purpose does not interfere with use of the room for another purpose.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-330, filed 2/1/91, effective 3/4/91.]

WAC 388-155-340 Toilets, handwashing sinks, and bathing facilities. (1) The licensee shall provide a minimum of one indoor flush-type toilet and one adjacent handwash sink.

(2) The licensee shall supply the child warm running water for handwashing at a temperature range no less than eighty-five degrees Fahrenheit and no more than one hundred and twenty degrees Fahrenheit.

(3) The licensee shall provide toileting privacy for the child of opposite sex six years of age and older and for other children demonstrating a need for privacy.

(4) The licensee shall provide toilets and handwashing sinks of appropriate height and size for the child in care or furnish safe, easily cleanable platforms impervious to moisture so the child can reach the toilet and handwashing sink.

(5) The licensee shall ensure a room used for toileting is ventilated.

(6) When a home serves the child not toilet-trained, the licensee shall provide developmentally appropriate equipment for the toileting and toilet training of the young child. The licensee shall sanitize the equipment after each child's use.

(7) The licensee shall provide the child with soap and individual cloth or paper towels for washing and drying the child's hand and face.

(8) If the home is equipped with a bathing facility, the licensee shall:

(a) Ensure the young child is supervised while using the bathing facility; and

(b) Equip the bathing facility with a conveniently located grab bar or other safety device such as a nonskid pad; or

(c) Make the bathing facility inaccessible to the child.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-340, filed 2/1/91, effective 3/4/91.]

WAC 388-155-350 Laundry. (1) The licensee shall maintain access to laundry washing and drying facilities, which may include using on-premises or off-site equipment.

(2) When washing and drying occurs on-site, the licensee shall locate equipment in an area inaccessible to the child, or make the equipment inaccessible to the child.

(3) The licensee shall use an effective method through temperature or chemical measures for adequately sanitizing the child's laundry contaminated with urine, feces, lice, scabies, or other infectious material.

(4) The licensee shall store the child's soiled laundry separately from clean laundry.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-350, filed 2/1/91, effective 3/4/91.]

WAC 388-155-360 Nap and sleep equipment. (1) The licensee shall provide a clean, separate, firm mat, cot, bed, mattress, play pen, or crib for each child five years of age and under remaining in care for six or more hours and for the child requiring a nap or rest period.

(2) The licensee shall ensure the child's mat is of sufficient length, width, and thickness to provide adequate comfort for the child to nap. The licensee may use a washable sleeping bag meeting the mat requirements for the toilet-trained child.

(3) The licensee shall ensure the child's cot is of sufficient length and width and constructed to provide adequate comfort for the child to nap. The licensee shall ensure the cot surface is of a material which can be cleaned with a detergent solution, disinfected, and allowed to air dry.

(4) The licensee shall clean the child's nap equipment as needed and between use by different children.

(5) The licensee shall separate the child's nap equipment when in use to facilitate child comfort and staff access.

(6) The licensee shall ensure the child's bedding:

(a) Consists of a clean sheet or blanket to cover the sleeping surface and a clean, suitable cover for the child;

(b) Is laundered weekly or more often and between use by different children; and

(c) Is stored separately from bedding used by another child.

(7) The licensee shall not use the upper bunk of a double deck bed for a preschool age or younger child.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-360, filed 2/1/91, effective 3/4/91.]

WAC 388-155-370 Storage. (1) The licensee shall provide accessible individual space for the child to store clothes and personal possessions.

(2) The licensee shall provide sufficient space to store equipment, supplies, records, files, cots, mats, and bedding.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-370, filed 2/1/91, effective 3/4/91.]

WAC 388-155-380 Home atmosphere. (1) The licensee shall provide a cheerful learning environment for the child consistent with a family home environment by placing visually stimulating decorations, pictures, or other attractive materials at appropriate heights for the child.

(2) The licensee shall maintain a safe and developmentally appropriate noise level, without inhibiting normal ranges of expression by the child, so provider and child can be clearly heard and understood in normal conversation.

(3) The licensee shall locate light fixtures and provide lighting intensities promoting good visibility and comfort for the child in care.

(4) The licensee shall maintain the temperature within the home at:

(a) Sixty-eight degrees Fahrenheit or more during the child's waking hours; and

(b) Sixty degrees Fahrenheit or more during the child's napping or sleeping hours.

(5) The licensee shall ventilate the home for the health and comfort of the child in care.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-380, filed 2/1/91, effective 3/4/91.]

WAC 388-155-390 Discrimination prohibited. The licensee shall comply with federal and state regulatory and statutory requirements, defined under chapter 49.60 RCW, regarding nondiscrimination in employment practices and client services.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-390, filed 2/1/91, effective 3/4/91.]

WAC 388-155-400 Religious activities. (1) Consistent with state and federal laws, the licensee shall respect and facilitate the rights of the child in care to observe the tenets of the child's faith.

(2) The licensee shall not punish or discourage the child for exercising these rights.

(3) If the home conducts religious activities, the licensee shall maintain a written description of the home's religious policies and practices affecting the child in care.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-400, filed 2/1/91, effective 3/4/91.]

WAC 388-155-410 Special requirements regarding American Indian children. When one or more Indian child receives care at the home, the licensee shall develop social service resources and training designed to meet the special needs of such children through coordination with tribal, Indian Health Service, Bureau of Indian Affairs social service staff, and appropriate urban Indian and Alaskan native consultants.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-410, filed 2/1/91, effective 3/4/91.]

WAC 388-155-420 Child abuse, neglect, and exploitation. The licensee and assistant shall protect the child in care from child abuse, neglect, or exploitation as required under chapter 26.44 RCW.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-420, filed 2/1/91, effective 3/4/91.]

WAC 388-155-430 Prohibited substances. (1) During operating hours or when the child is in care, the licensee, assistant, and volunteers on the premises or caring for the child off-site shall not be under the influence of or consume an:

- (a) Alcoholic beverage; or
- (b) Illegal drug.

(2) The licensee shall prohibit smoking in:

- (a) All areas of the home used by the child during hours of operation when the child is in care; and
- (b) A motor vehicle when the licensee or assistant transports a child.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-430, filed 2/1/91, effective 3/4/91.]

WAC 388-155-440 Limitations to persons on premises. (1) During home operating hours or while the child is in care, only the child's parent, the licensee, an employee, the licensee's family member, a volunteer, or an authorized rep-

resentative of a governmental agency shall have unsupervised or regular access to the child in care.

(2) The licensee shall allow the parent of the child in care unsupervised access only to the parent's child.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-440, filed 2/1/91, effective 3/4/91.]

WAC 388-155-450 Child records and information. The licensee shall maintain on the premises organized confidential records and information concerning each child in care. The licensee shall ensure the child's record contains, at a minimum:

(1) Registration data:

(a) Name, birthdate, dates of enrollment and termination, and other identifying information; and

(b) Name, address, and home and business telephone number of the parent and other person to be contacted in case of emergency.

(2) Authorizations:

(a) Name, address, and telephone number of the person authorized to remove from the home the child under care;

(b) Written parental consent for transportation provided by the home, including field trips and swimming, when the child participates in these activities. A parent-signed blanket consent form may authorize the child's off-site travel; and

(c) Written parental consent, or court order, for providing medical care and emergency surgery, except for such care authorized by law.

(3) Medical and health data:

(a) A health history, obtained when the licensee enrolls the child for care. The history includes:

(i) The date of the child's last physical examination;

(ii) Allergies;

(iii) Special health problems and other pertinent health information;

(iv) Immunization history as required under WAC 388-155-220;

(v) Name, address, and telephone number of the child's health care provider or facility; and

(vi) Special developmental problems.

(b) Date and kind of illness and injury occurring on the premises, including the treatment given by the licensee; and

(c) Medication given indicating dosage, date, time, and name of the dispensing person.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-450, filed 2/1/91, effective 3/4/91.]

WAC 388-155-460 Home records. The licensee shall maintain the following documentation on the premises:

(1) The attendance records, completed daily, including arrival and departure times;

(2) A copy of the report sent to the licensor about the illness or injury to the child in care requiring medical treatment or hospitalization;

(3) The twelve-month record indicating the date and time the licensee conducted the required monthly fire evacuation drills;

(4) The twelve-month record indicating the date the licensee tested the battery-powered smoke detector monthly; and

(5) Attendance records and invoices for state-paid children for at least five years.

[Statutory Authority: RCW 74.12.340. 94-13-201 (Order 3745), § 388-155-460, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-460, filed 2/1/91, effective 3/4/91.]

WAC 388-155-470 Personnel records. (1) Each assistant and volunteer having unsupervised or regular access to the child in care shall complete and submit to the licensee by the date of hire:

(a) An application for employment on a department-prescribed form, or its equivalent; and

(b) A criminal history and background inquiry form.

(i) The licensee shall submit this form to the department for the employee and volunteer, within seven calendar days of the assistant's or volunteer's first day of employment, permitting a criminal and background history check.

(ii) The department shall discuss the result of the criminal history and background inquiry information with the licensee, when applicable.

(2) The licensee, assistant, and volunteer shall have on file at the home:

(a) An employment application, including work and education history;

(b) Documentation of criminal history and background inquiry form submission;

(c) A record of the tuberculin skin test results, x-ray, or an exemption to the skin test or x-ray;

(d) Documentation of HIV/AIDS education and training;

(e) Documentation of current first aid and CPR training, when applicable; and

(f) Documentation of basic and annual training required under WAC 388-155-180 (2)(d) and 388-155-200 (2)(c), when applicable.

[Statutory Authority: RCW 74.15.030. 98-24-052, § 388-155-470, filed 11/25/98, effective 12/26/98; 91-04-048 (Order 3136), § 388-155-470, filed 2/1/91, effective 3/4/91.]

WAC 388-155-480 Reporting of death, injury, illness, epidemic, or child abuse. The licensee shall report immediately:

(1) A death, serious injury requiring medical treatment, or illness requiring hospitalization of a child in care, by telephone and in writing, to the parent, licensor, and child's social worker, if any;

(2) An instance when the licensee or assistant has reason to suspect the occurrence of physical, sexual, or emotional child abuse, child neglect, or child exploitation, as required under chapter 26.44 RCW, by telephone, to child protective services or local law enforcement; or

(3) An occurrence of food poisoning or communicable disease, as required by the state board of health, by telephone, to the local public health department.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-480, filed 2/1/91, effective 3/4/91.]

WAC 388-155-490 Reporting of circumstantial changes. A family child care home license is valid only for the person and address named on the license. The licensee

shall promptly report to the licensor major changes in premises, activities and routines, the assistant, or members of the household affecting the home's capacity classification, delivery of safe, developmentally appropriate services, or continued eligibility for licensure. A major change includes the:

(1) Home's address, location, or phone number;

(2) Maximum number and age ranges of children the licensee wishes to serve as compared to current license specifications;

(3) Number and qualifications of the home's staff that may affect competencies to implement the specified activities and routines, including the death, retirement, or incapacity of a licensee;

(4) Name by which the home is commonly known;

(5) Occurrence of a fire, major structural change, or damage to the premises from any cause; and

(6) Plans for major remodeling of the home, including planned use of space not previously department-approved.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-490, filed 2/1/91, effective 3/4/91.]

WAC 388-155-500 Posting requirements. The licensee shall post the following items, clearly visible to the parents and the assistant:

(1) The home's child care license issued under this chapter;

(2) Evacuation plans and procedures; and

(3) Emergency telephone numbers.

[Statutory Authority: RCW 74.15.030. 91-04-048 (Order 3136), § 388-155-500, filed 2/1/91, effective 3/4/91.]

WAC 388-155-600 Occupancy restrictions. (1) Any home used for child day care purposes for fewer than thirteen children is considered to be a Group R, Division 3 occupancy per the state building code. Family child day care homes must meet the minimum construction and fire and safety requirements for one and two family dwellings.

If a portion of the home is used for purposes other than a dwelling, such as a garage, automotive repair shop, cabinet and/or furniture making or refinishing or similar use, a fire wall is required between the dwelling and the other use.

(2) Only one exit door from a family child day care home need be of the pivoted or side hinged swinging type. Approved sliding doors may be used for other exits.

(3) In family child day care home, each floor level used for family child day care purposes shall be provided with two exits, usually located at opposite ends of the building or floor.

(4) Basements located more than four feet below grade level shall not be used for family child day care purposes unless one of the following conditions exists:

(a) Two exit stairways from the basement open directly to the exterior of the building without entering the first floor; or

(b) One of the two required exits discharges directly to the exterior from the basement level and the other exit is an interior stairway with a self-closing door installed at the top or bottom leading to the floor above; or

(c) One of the two required exits is an operable window or door, approved for emergency escape or rescue, that opens

directly to a public street, public alley, yard or exit court and the other may be an approved interior or exterior stairway; or

(d) A residential sprinkler system is provided throughout the entire home in accordance with standards of the National Fire Protection Association.

(5) The family child care home licensee shall ensure that any floor located more than four feet above grade level is not occupied by children for family child day care purposes except for the use of toilet facilities while under supervision of a staff person.

Family child day care may be allowed on the second story if one of the following conditions exists:

(a) There are two exit stairways from the second story which open directly to the exterior of the building without entering the first floor; or

(b) There is an exit which discharges directly to the exterior from the second story level, and a second interior stairway with a self-closing door installed at the top or bottom of the interior stair leading to the floor below; or

(c) A residential sprinkler system is provided throughout the entire building in accordance with standards of the National Fire Protection Association.

(6) The maximum travel distance from any point in the home to an exterior exit door shall not exceed one hundred fifty feet.

(7) Every room used for child care (except bathrooms) shall have:

(a) At least one operable window or door approved for emergency escape or rescue which shall open directly into a public street, public alley, yard or exit court. The units shall be operable from the inside to provide a full clear opening without the use of separate tools.

All escape or rescue windows shall have a minimum net clear openable area of 5.7 square feet. The minimum net clear openable height dimension shall be twenty-four inches. The minimum net clear openable width dimension shall be twenty inches. When windows are provided as a means of escape or rescue, they shall have a finished sill height of not more than forty-four inches above the floor; or

(b) Doors leading to two separate exit ways; or

(c) A door leading directly to the exterior of the building.

(8) A stationary platform may be used under a window to attain the forty-four inches above the floor.

(9) Exit doors shall be easy to open to the full open position.

(10) Exit doors and windows shall be able to be opened from the inside without having to use a key. Night latches, dead bolts, security chains, manually operated edge or surface mounted flush bolts and surface bolts are prohibited.

The locking arrangement on outside exit doors shall be such that they will automatically unlock when the doorknob is turned from the inside.

(11) The licensee shall ensure that obstructions are not placed in corridors, aisles, doorways, doors, stairways or ramps.

(12) No space which is accessible only by ladder, folding stairs or trap doors, shall be used for family child day care purposes.

(13) Every bathroom door lock shall be designed to permit the opening of the locked door from the outside in an

emergency. The opening device shall be readily accessible to the staff.

(14) Every closet door latch shall be such that children can open the door from inside the closet.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-600, filed 4/26/96, effective 5/27/96.]

WAC 388-155-605 Hazardous areas. Rooms or spaces containing a commercial-type kitchen, boiler, maintenance shop, janitor closet, laundry, woodworking shop, flammable or combustible storage, painting operation, or parking garage shall be separated from the family child day care home or any exits by a fire wall.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-605, filed 4/26/96, effective 5/27/96.]

WAC 388-155-610 Single station smoke detectors. (1) Smoke detectors shall be located in all sleeping and napping rooms in family child day care homes.

(2) In family child day care homes with more than one story, and in family child day care homes with basements, a smoke detector shall be installed on each story and in the basement.

(3) In family child day care homes where a story or basement is split into two or more levels, the smoke detector shall be installed in the upper level, except that when the lower level contains a sleeping or napping area, a smoke detector shall be located on each level.

(4) When sleeping or napping rooms are on an upper level, the smoke detector shall be placed on the ceiling of the upper level in close proximity to the stairway and in each sleeping/napping room.

(5) In a family child day care home where the ceiling height of a room open to the hallway serving sleeping or napping rooms exceeds that of the hallway by twenty-four inches or more, smoke detectors shall be installed in both the hallway and the sleeping/napping room.

(6) Smoke detectors shall sound an alarm audible in all areas of the building.

(7) In new construction, required smoke detectors shall receive their primary power from the building wiring when such wiring is served from a commercial source. Wiring shall be permanent and without a disconnecting switch other than those required for overcurrent protection.

(8) Smoke detectors may be battery operated when installed in existing buildings or buildings without commercial power.

(9) Where battery operated smoke detectors are installed, at least one extra battery of the type and size specified for the battery operated smoke detector shall be maintained upon the premises.

(10) Single station smoke detectors shall be tested at monthly intervals or in a manner specified by the manufacturer. Records of such testing shall be maintained upon the premises.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-610, filed 4/26/96, effective 5/27/96.]

WAC 388-155-620 Alternate means of sounding a fire alarm. In addition to single station smoke detectors,

family child day care homes shall provide an alternate means for sounding a fire alarm. A police type whistle or similar device is adequate for meeting this requirement, provided that whatever method is selected is limited to an evacuation emergency only.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-620, filed 4/26/96, effective 5/27/96.]

WAC 388-155-630 Fire extinguisher. (1) At least one approved 2A, 10B:C rated fire extinguisher shall be provided on each floor level occupied for day care use. Such extinguisher shall be located in the area of the normal path of egress. The maximum travel distance to an extinguisher shall not exceed seventy-five feet.

(2) Fire extinguishers shall be operationally ready for use at all times.

(3) Fire extinguisher shall be kept on a shelf or mounted in the bracket provided for this purpose so that the top of the extinguisher is not more than five feet above the floor.

(4) The licensee shall ensure that fire extinguishers receive annual maintenance certification by a firm specializing in and licensed to do such work. Maintenance means a thorough check of the extinguisher to include examination of:

- (a) Mechanical parts;
- (b) Extinguishing agent; and
- (c) Expelling means.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-630, filed 4/26/96, effective 5/27/96.]

WAC 388-155-640 Fire prevention. (1) The licensee shall ensure that the local fire department is requested to visit the family child day care home to become familiar with the facility and to assist in planning evacuation or emergency procedures. Where a fire department does not provide this service, the licensee shall document this contact.

(2) Furnace rooms shall be maintained free of lint, grease and rubbish accumulations and other combustibles and suitably isolated, enclosed or protected.

(3) Flammable or combustible materials shall be stored away from exits and in areas which are not accessible to children. Combustible rubbish shall not be allowed to accumulate and shall be removed from the building or stored in closed, metal containers.

(4) The licensee shall keep all areas used for child care clean and neat, making sure that all waste generated daily is removed from the building and disposed of in a safe manner outside the building. All containers used for the disposal of waste material shall be of noncombustible materials with tops. Electrical motors shall be kept dust-free.

(5) Open-flame devices capable of igniting clothing shall not be left on, unattended or used in a manner which could result in an accidental ignition of children's clothing. Candles shall not be used.

(6) A flashlight shall be available for use as an emergency power source.

(7) All electrical circuits, devices and appliances shall be properly maintained. Circuits shall not be overloaded. Extension cords and multi-plug adapters shall not be used in lieu of permanent wiring and proper receptacles.

(8) The use of portable space heaters of any kind is prohibited.

(9) Approved numbers or addresses shall be placed on all new and existing homes and in the driveway to the house when the house is not visible from the road. The numbers or address shall be in such a position as to be plainly visible and legible from the street or road fronting the property. Said numbers shall contrast with their background.

(10) Fireplaces, woodstoves, similar devices and their connections shall be approved by the local building official. If the woodstove is used as a sole source of heat or is used during hours of operation, such devices shall be cleaned, maintained and inspected on at least an annual basis by a person or firm specializing in such work and licensed.

Where open flames and/or hot surfaces are accessible, approved barriers shall be erected to prevent children from coming in contact with the open flames and/or hot surfaces.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-640, filed 4/26/96, effective 5/27/96.]

WAC 388-155-650 Sprinkler system maintenance. Sprinkler systems, if installed, shall be tested on an annual basis by a person or agency qualified by licensing. The results of the system test shall be documented on forms provided by the licensor and maintained at the home for inspection by the licensor.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-650, filed 4/26/96, effective 5/27/96.]

WAC 388-155-660 Fire evacuation plan. Each home shall develop written fire evacuation plans. The evacuation plan shall include an evacuation floor plan, identifying exit doors and windows, that shall be posted at a point clearly visible to the assistant and parents. Plans shall include the following:

- (1) Action to be taken by the person discovering a fire;
- (2) Method to be used for sounding an alarm on the premises;
- (3) Action to be taken for evacuation of the building and assuring accountability of the children; and
- (4) Action to be taken pending arrival of the fire department.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-660, filed 4/26/96, effective 5/27/96.]

WAC 388-155-670 Fire evacuation drill. A fire evacuation drill shall be conducted at least once each month. A written record, the fire safety record and evacuation plan, shall be maintained and posted on the premises indicating the date, time and other required entries on the form. Such forms are available from the office of child care policy.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-670, filed 4/26/96, effective 5/27/96.]

WAC 388-155-680 Staff training. The licensee and each employee or assistant shall be familiar with all elements of the fire evacuation plan and must be capable of accomplishing the following:

- (1) Operation of fire extinguisher installed on the premises.

(2) Testing smoke detectors (single station types).

(3) Conducting frequent inspections of the home to identify fire hazards and take action to correct any hazards noted during the inspection. Such inspections should be conducted on a monthly basis and records kept on the premises for review by the licensor.

[Statutory Authority: RCW 74.12.340 and chapter 74.15 RCW. 96-10-042 (Order 9373), § 388-155-680, filed 4/26/96, effective 5/27/96.]

Chapter 388-160 WAC

MINIMUM LICENSING REQUIREMENTS FOR OVERNIGHT YOUTH SHELTERS

WAC

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WAC 388-160-010 Authority. The following minimum licensing requirements for overnight youth shelter rules

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are adopted under chapter 74.15 RCW, Agencies for care of children, expectant mothers, developmentally disabled.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-010, filed 7/21/93, effective 8/21/93.]

WAC 388-160-020 Definitions. (1) Terms defined under this chapter shall have the same meanings as definitions described under chapter 74.15 RCW, except as otherwise provided herein.

(2) "Capacity" means the maximum number of persons under care at a given moment in time.

(3) "Child" and "juvenile" means any person under the chronological age of eighteen years of age.

(4) "Department" means the department of social and health services.

(5) "Full-time care provider" or "full-time care facility" means a foster family home, group care facility, maternity home, crisis residential center, and juvenile detention facility for a child or expectant mothers.

(6) "Overnight youth shelter" means a licensed facility operated by a nonprofit agency providing overnight shelter to a homeless or runaway youth because of family problems or dysfunctions. Overnight youth shelters do not provide domiciliary care during daytime hours.

(7) "Youth" means a child or young adult through twenty years of age.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-020, filed 7/21/93, effective 8/21/93.]

WAC 388-160-030 Exceptions to rules. (1) In individual cases the department, at its discretion for good cause, may waive specific requirements and may approve alternative methods of achieving the intent of specific requirements.

(2) The department may neither waive specific requirements nor approve alternate methods of achieving the content of specific requirements if it jeopardizes the safety or welfare of the person in care, as described under subsection (1) of this section.

(3) The department may approve a waiver request only for a specific purpose or child and for a specific period of time not exceeding the expiration date of the license. The licensee may apply anew for the waiver when reapplying for a license.

(4) The department may limit or restrict a license issued to a licensee or applicant in conjunction with a waiver.

(5) The licensee or applicant applying for a waiver shall do so in writing and the licensee shall maintain a copy of the waiver.

(6) The department's denial of a licensee's or applicant's waiver request shall not be subject to appeal under chapter 34.05 RCW.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-030, filed 7/21/93, effective 8/21/93.]

WAC 388-160-040 Effect of local ordinances. (1) The department shall issue or deny a license on the basis of an applicant's compliance with the department's minimum licensing requirements.

(2) The department shall not enforce local ordinances, such as zoning regulations and local building codes.

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[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-040, filed 7/21/93, effective 8/21/93.]

WAC 388-160-050 Fire standards. Overnight youth shelters shall conform to the rules and regulations adopted by the Washington state fire marshal's office establishing minimum standards for fire prevention and the protection of life and property against fire as required under RCW 74.15.050 and WAC 212-12-001. The Washington state fire marshal's standards are contained in the current state building code.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-050, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-050, filed 7/21/93, effective 8/21/93.]

WAC 388-160-060 Certification of exempt agency. An agency legally exempt from licensing may not be licensed. However, at the agency's request, the department may certify an agency as meeting licensing and other pertinent requirements to enable an agency to be eligible for the receipt of funds or for other legitimate purposes if the department's investigation finds the agency in compliance with the licensing requirements. In such cases, unless otherwise clearly evident from the text, the department's requirements and procedures for an agency's licensing apply equally to certification.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-060, filed 7/21/93, effective 8/21/93.]

WAC 388-160-070 Application or reapplication for license or certification—Investigation. (1) A person or organization applying for a license or for certification under this chapter shall:

- (a) Submit the application on forms prescribed by the department;
- (b) Comply with department procedures;
- (c) Initiate the application in the name of the person or legal entity responsible for the agency's operation; and
- (d) Include with the application:
 - (i) Employment and educational history of the person charged with the active management of the agency;
 - (ii) Completed forms enabling the department to:
 - (A) Perform a criminal history check;
 - (B) Check the department's master files for each staff or volunteer of the agency having unmonitored access to the child, expectant mother, or developmentally disabled person; and
 - (C) Share this information with the applicant or licensee.
 - (2) The department may:
 - (a) Require additional information from the applicant, licensee, their staff, and persons having access to a child under care as the department deems necessary including, but not limited to:
 - (i) Sexual deviancy evaluations;
 - (ii) Substance and alcohol abuse evaluations;
 - (iii) Psychiatric evaluations;
 - (iv) Psychological evaluations; and
 - (v) Medical evaluations.
 - (b) Perform corollary investigations of the applicant, licensee, and their staff, and as the department deems necessary,

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including accessing of criminal histories and law enforcement files.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-070, filed 7/21/93, effective 8/21/93.]

WAC 388-160-080 Limitations on licenses and dual licensure. The department shall not issue a license to an applicant for both an overnight youth shelter and another category of residential care which the department licenses or is licensed by another department. The department may authorize an exception only if it is clearly evident that care of one category of client does not interfere with the safety and quality of care provided to other client categories.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-080, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-080, filed 7/21/93, effective 8/21/93.]

WAC 388-160-090 General qualifications of licensee, applicant, and persons on the premises. (1) The applicant, licensee, staff, and other person on the premises shall be a person of good character.

(2) The licensee or applicant shall demonstrate that the licensee or applicant, child care staff, volunteer, and other person having access to a person under care have the understanding, ability, physical health, emotional stability, and personality suited to meet the physical, mental, emotional, and social needs of the person under care.

(3) A person shall be disqualified from providing care if the department determines that the person is ineligible to provide care under chapter 388-330 WAC or that person has abused, neglected, or sexually exploited a child as those acts or omissions are defined in RCW 26.44.020 and WAC 388-15-130.

(4) The department may, at any time, require the licensee or person on the premises to provide additional information so the department can determine whether the licensee, adoptive applicant, child care staff, volunteer, and other person having access to a child in care meet the qualifications under subsections (1), (2), and (3) of this section. The department may require the licensee or person on the premises to provide additional information including, but not limited to:

- (a) Sexual deviancy evaluations;
- (b) Substance and alcohol abuse evaluations;
- (c) Psychiatric evaluations;
- (d) Psychological evaluations; and
- (e) Medical evaluations.

[Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-160-090, filed 4/26/96, effective 5/27/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-090, filed 7/21/93, effective 8/21/93.]

WAC 388-160-100 Age of licensee. An applicant for an overnight youth shelter license under this chapter shall be twenty-one or more years of age.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-100, filed 7/21/93, effective 8/21/93.]

WAC 388-160-110 Posting of license. All licensees shall post the license issued under this chapter at the over-

night youth shelter in a place accessible and conspicuous to the public.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-110, filed 7/21/93, effective 8/21/93.]

WAC 388-160-120 Licensure—Denial, suspension, or revocation. (1) Before granting a license and as a condition for continuance of a license, the department shall consider the ability of each applicant, licensee, and chief executive officer, if any, to operate the agency under the law and this chapter. The department shall consider such persons separately and jointly as applicants or licensees and if any one be deemed disqualified by the department under chapter 74.15 RCW or this chapter, the department may deny, suspend, revoke, or not renew the license. The department shall deny, suspend, revoke, or not renew a license for the following reasons:

(a) The department shall disqualify any person engaging in illegal use of drugs or excessive use of alcohol;

(b) The department shall disqualify any person who has abused, neglected, or sexually exploited a child as those acts or omissions are defined in RCW 26.44.020 and WAC 388-15-130, is ineligible to provide care because of a criminal history under chapter 388-330 WAC, or allows such person on the premises;

(c) The department shall disqualify any person convicted of a felony or released from a prison within seven years of the date of application for the license because of the conviction, when:

(i) The person's conviction is reasonably related to the person's competency to exercise responsibilities for ownership, operation, or administration of an agency; and

(ii) The department determines, after investigation, the person has not been sufficiently rehabilitated to warrant public trust.

(d) The department shall not grant a license to an applicant who, in this state or elsewhere:

(i) Has been denied a license to operate an agency for the care of a child, an expectant mother, or a developmentally disabled adult; or

(ii) Had a license to operate such an agency suspended or revoked.

(2) An applicant of an overnight youth shelter may establish by clear, cogent, and convincing evidence the ability to operate an agency under this chapter. The department may waive the provision and license the applicant as described under subdivision (1)(d) of this section.

(3) The department may deny, suspend, revoke, or not renew a license for failure to comply with the provisions of chapter 74.15 RCW and rules contained in this chapter. The department shall deny, suspend, revoke, or not renew a license for the following reasons:

(a) Obtaining or attempting to obtain a license by fraudulent means or misrepresentation, including:

(i) Making materially false statements on the application; or

(ii) Material omissions which would influence appraisal of the applicant's or provider's suitability.

(b) Permitting, aiding, or abetting the commission of any illegal act on the premises;

(c) Permitting, aiding, or abetting the abuse, neglect, exploitation, or cruel or indifferent care to a person under care;

(d) Repeatedly:

(i) Providing insufficient personnel relative to the number and types of persons under care; or

(ii) Allowing a person unqualified by training, experience, or temperament to care for, or be in contact with, the person under care.

(e) Misappropriation of the property of a person under care;

(f) Failure or inability to exercise fiscal responsibility and accountability in respect to operation of the agency;

(g) Failure to provide adequate supervision to a person under care;

(h) Refusal to admit authorized representatives of the department, department of health, or state fire marshal to inspect the premises;

(i) Refusal to permit:

(A) Authorized representatives of the department and the department of health to have access to the records necessary for the operation of the agency; or

(B) The department representatives to interview agency staff and clients.

(j) Knowingly having an employee or volunteer on the premises who has made misrepresentation or significant omissions on the application for employment or volunteer service; and

(k) Refusal or failure to supply necessary additional department-requested information.

(4) The department may deny, suspend, revoke, or not renew or modify a license for violation of any condition or limitation upon licensure including, but not limited to, providing care for:

(a) More children than the number for which the agency is licensed; or

(b) Children of ages different from the ages for which the agency is licensed.

(5) The department shall deny, suspend, or revoke a licensee's license when the applicant, licensee, or person on the premises is a perpetrator of child abuse or has been convicted of a crime as listed under WAC 388-330-030(1). The department may grant a licensee or provider a waiver if it is demonstrated by clear, cogent, and convincing evidence that such person is rehabilitated and is able to comply with licensing requirements. In making this determination, the department shall consider:

(a) The seriousness and circumstances of the person's illegal act;

(b) The number of crimes of which the person was convicted;

(c) The amount of time passed since the person committed the illegal act;

(d) The age of the person at the time of convictions;

(e) Whether the person has entered and successfully completed all appropriate rehabilitative services, including those services ordered by a court;

(f) The behavior of the person since the illegal act was committed;

- (g) Recommendations of persons closely associated with the person;
- (h) The duties the person would perform at the agency, and the vulnerability of the persons under care; and
- (i) Other evidence of rehabilitation.

If the department licenses or approves a person under this section, the department may place limitations or conditions on the person in the performance of the person's duties at the agency.

(6) The department's notice of a denial, revocation, suspension, or modification of a license shall be governed by RCW 43.20A.205. The provider's right to an adjudicative proceeding is in the same law.

(a) A provider contesting a department licensing decision shall within twenty-eight days of receipt of the decision:

(i) File a written application for an adjudicative proceeding by a method showing proof of receipt with the office of appeals; and

(ii) Include in or with the application:

(A) A specific statement of the issues and law involved;

(B) The grounds for contesting the department decision; and

(C) A copy of the department decision.

(b) The proceeding shall be governed by the Administrative Procedure Act chapter 34.05 RCW, RCW 43.20A.205, this chapter, and chapter 388-08 WAC. If any provision of this chapter conflicts with chapter 388-08 WAC, the provision in this chapter governs.

[Statutory Authority: RCW 74.15.030, 96-10-043 (Order 3974), § 388-160-120, filed 4/26/96, effective 5/27/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-120, filed 7/21/93, effective 8/21/93.]

WAC 388-160-130 Licensed capacity. (1) The number of persons for whom the department will license an agency is dependent upon the evaluation of:

- (a) The physical accommodations of the agency;
- (b) The numbers and skills of the licensee, staff, family members and volunteers; and
- (c) The ages and characteristics of the persons to be served.

(2) The department shall not license an agency for the care of more persons than permitted by the rules regarding the category of care for which the license is sought.

(3) The department may license an agency for the care of fewer persons than normally permitted by the rules based on the evaluation of items listed under subsection (1) of this section.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-130, filed 7/21/93, effective 8/21/93.]

WAC 388-160-140 Discrimination prohibited. The licensee shall comply with federal and state statutory and regulatory requirements regarding nondiscrimination in employment practices and client services as described under chapter 49.60 RCW.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-140, filed 7/21/93, effective 8/21/93.]

WAC 388-160-150 Religious activities. The overnight youth shelter licensee shall:

- (1) Respect the rights of persons in care to observe the tenets of the person's faith and shall facilitate those rights consistent with state and federal laws;

- (2) Not punish a person in care for exercising these rights;

- (3) Submit to the department a written description of any religious policies and practices.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-150, filed 7/21/93, effective 8/21/93.]

WAC 388-160-160 Discipline. (1) The overnight youth shelter licensee shall state disciplinary practices in writing. Discipline shall be a responsibility of the licensee or staff, and shall not be prescribed or administered by persons under care. Discipline shall be based on an understanding of the person's needs and stage of development. A person's discipline shall be designed to help the person develop inner control, acceptable behavior, and respect for the rights of others.

(2) The licensee shall ensure a person's discipline is fair, reasonable, consistent, and related to the person's behavior. A licensee shall not administer cruel and unusual discipline, discipline hazardous to health, and frightening or humiliating discipline.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-160, filed 7/21/93, effective 8/21/93.]

WAC 388-160-170 Corporal punishment. (1) Corporal punishment is prohibited.

(2) Prohibited corporal punishment shall not include the use of such amounts of physical restraint as may be reasonable and necessary to:

- (a) Protect a person on the premises from physical injury;

- (b) Obtain possession of a weapon or other dangerous object; and

- (c) Protect property from serious damage.

(3) The licensee of an overnight youth shelter shall not use mechanical restraints including, but not limited to:

- (a) Handcuffs;

- (b) Belt restraints; and

- (c) Locked time-out rooms.

(4) The licensee shall not use physical restraints which could be injurious including, but not limited to:

- (a) Large adult sitting on or straddling a small child;

- (b) Sleeper holds;

- (c) Arm twisting;

- (d) Hair holds; and

- (e) Throwing a child or youth against a wall, furniture, or other large immobile object.

(5) Staff employed in a facility where it may be necessary to restrain a child shall be trained in the use of appropriate restraining techniques.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-170, filed 7/21/93, effective 8/21/93.]

WAC 388-160-180 Abuse, neglect, or exploitation. An overnight youth shelter licensee shall protect persons,

while in the licensee's care, from child abuse or neglect as defined under RCW 26.44.020(12).

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-180, filed 7/21/93, effective 8/21/93.]

WAC 388-160-190 Site and telephone. An overnight youth shelter licensee shall locate the shelter on a well-drained site free from hazardous conditions and accessible to other facilities necessary to carry out its program. The licensee shall ensure the shelter has one or more telephones on the premises accessible for emergency use at all times.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-190, filed 7/21/93, effective 8/21/93.]

WAC 388-160-200 Equipment, safety, and maintenance. (1) An overnight youth shelter licensee shall:

- (a) Maintain the physical plant, premises, and equipment in a clean and sanitary condition, free of hazards, and in good repair;
- (b) Provide handrails on stairs as determined necessary by the department;
- (c) Have available one or more emergency light sources, such as a flashlight, in operational condition; and
- (d) Provide toilet rooms and other rooms subject to moisture with washable, moisture impervious floors.

(2) Shelter staff members shall have a means to gain rapid access to any bedroom, toilet room, shower room, bathroom, or other room occupied by youth should an emergency need arise.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-200, filed 7/21/93, effective 8/21/93.]

WAC 388-160-210 Firearms and other weapons. An overnight youth shelter licensee shall ensure no firearms or other weapons are on the premises except those confiscated and secured from youth upon admission and these shall be locked up.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-210, filed 7/21/93, effective 8/21/93.]

WAC 388-160-220 Prohibited substances. (1) During operating hours when youth are in care, the overnight shelter licensee, staff, and volunteers on shelter premises or caring for youth off-site shall not be under the influence of, consume, or possess an:

- (a) Alcoholic beverage; or
- (b) Illegal drug.

(2) The overnight shelter licensee shall prohibit smoking in:

- (a) A transport vehicle when shelter staff are transporting youth in care; and
- (b) The shelter when youth are in care; except, the licensee may permit a person to smoke only in a designated smoking room which is ventilated to the outside in such a manner that passive tobacco smoke cannot contaminate the indoor shelter air.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-220, filed 7/21/93, effective 8/21/93.]

WAC 388-160-230 Storage. An overnight youth shelter provider shall ensure a shelter provides:

- (1) Suitable space as needed for the storage of:
 - (a) Clothing and personal possessions of youth in care;
 - (b) Records and files;
 - (c) Cots;
 - (d) Mats and bedding; and
 - (e) Cleaning supplies and other materials.
- (2) A secure area for cleaning supplies, toxic substances, poisons, aerosols, and items bearing warning labels, which is inaccessible to youth. The provider shall ensure all containers filled from a stock supply bear a label identifying the product name and concentration.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-230, filed 7/21/93, effective 8/21/93.]

WAC 388-160-240 Bedrooms and sleeping areas. An overnight youth shelter licensee shall ensure the shelter:

- (1) Provides sleeping areas not less than fifty square feet per occupant of unobstructed floor area with ceiling height of not less than seven feet, six inches;
- (2) Not use hallways and kitchens as sleeping rooms;
- (3) Maintains a space not less than thirty inches between sleeping youths;
- (4) Provides sleeping areas separated by a visual barrier five or more feet high for each sex of youth in care; and
- (5) In facilities caring for youth sixteen through twenty years of age, separates youths under eighteen years of age from youths eighteen through twenty years of age by a supervised open space or a physical barrier to prevent contact.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-240, filed 7/21/93, effective 8/21/93.]

WAC 388-160-250 Kitchen facilities. An overnight youth shelter licensee shall ensure the shelter providing food service:

- (1) Provides for the proper storage, preparation, and service of food to meet the needs of the program;
- (2) Has facilities and implements practices as required under chapter 246-215 WAC, rules and regulations of the state board of health, which governs food service sanitation.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-250, filed 7/21/93, effective 8/21/93.]

WAC 388-160-260 Housekeeping sink. An overnight youth shelter shall have and use:

- (1) A method of drawing clean mop water; and
- (2) An appropriate method of waste water disposal.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-260, filed 7/21/93, effective 8/21/93.]

WAC 388-160-270 Laundry. An overnight youth shelter shall:

- (1) Provide for separate storage of soiled linen and clean linen;
- (2) Have access to laundry washing and drying facilities, which may include using on-premises or off-site equipment;
- (3) Locate laundry equipment, if on the premises, in an area separate from the kitchen; and

(4) Sanitize laundry using a hot water temperature of at least one hundred thirty degrees Fahrenheit or an effective chemical method, or have the laundry done by a commercial service.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-270, filed 7/21/93, effective 8/21/93.]

WAC 388-160-280 Toilets, handwashing sinks, and bathing facilities. An overnight youth shelter shall provide:

(1) Two or more indoor flush-type toilets, each with one nearby handwashing sink with hot and cold running water;

(2) Toilets and handwashing sinks in a ratio of one toilet and sink for each eight persons on the premises plus the major fraction thereof, allowing four additional persons before requiring additional fixtures;

(3) Privacy for persons of the opposite sex at toilets, and bathing facilities, if provided;

(4) Hot and cold running water not exceeding one hundred twenty degrees Fahrenheit at handwashing sinks, and bathing facilities, if provided;

(5) A conveniently located grab bar or nonslip floor surfaces in bathing facilities, if provided;

(6) Urinals in lieu of toilets only if the urinals do not replace more than one-third of the total required toilets; and

(7) Soap and individual towels, disposable towels, or other approved single-use hand drying devices at handwashing sinks, and any bathing facilities if bathing facilities are provided.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-280, filed 7/21/93, effective 8/21/93.]

WAC 388-160-290 Lighting. An overnight youth shelter shall provide and locate fixtures for the comfort and safety of the youth in care.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-290, filed 7/21/93, effective 8/21/93.]

WAC 388-160-300 Pest control. An overnight youth shelter shall keep the premises free from rodents, flies, cockroaches, and other insects.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-300, filed 7/21/93, effective 8/21/93.]

WAC 388-160-310 Sewage and liquid wastes. An overnight youth shelter shall discharge sewage and liquid wastes into:

(1) A public sewer system; or

(2) A local health authority or department approved independent sewage system.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-310, filed 7/21/93, effective 8/21/93.]

WAC 388-160-320 Water supply. An overnight youth shelter shall provide:

(1) A potable water supply approved by the local health authority or department; and

(2) Disposable paper cups, individual drinking cups or glasses, or inclined-jet drinking fountains.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-320, filed 7/21/93, effective 8/21/93.]

WAC 388-160-340 Health and emergency policies and procedures. An overnight youth shelter shall have:

(1) Current written health policies and procedures including, but not limited to, first aid, infection control, care of minor illnesses, and general health practices and actions to be taken in event of medical and other emergencies;

(2) These health policies and procedures readily available for staff orientation and for implementation; and

(3) Emergency phone numbers posted next to the phone.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-340, filed 7/21/93, effective 8/21/93.]

WAC 388-160-350 First aid. An overnight youth shelter shall:

(1) Have one or more persons having completed a current basic Red Cross first-aid course or a department-approved first-aid course, and current training in cardiopulmonary resuscitation (CPR) present at all times youth are in care;

(2) Maintain documentation of persons having completed the first aid and CPR training on the premises; and

(3) Keep first-aid supplies readily available to shelter staff.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-350, filed 7/21/93, effective 8/21/93.]

WAC 388-160-360 Medication management. An overnight youth shelter shall:

(1) Secure any medication brought into the shelter by a youth so it is unavailable to other youth in care;

(2) Supervise self-administration of a medication according to the prescription or manufacturer's label on the original medication container; and

(3) Return a medication of a youth when the youth leaves the facility, or properly dispose of the medication if left behind by the youth.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-360, filed 7/21/93, effective 8/21/93.]

WAC 388-160-370 Staff health. Each licensee, employee, adult volunteer, and other adult persons having regular contact with persons in care shall have a tuberculin skin test, by the Mantoux method, upon overnight youth shelter employment or licensing unless medically contraindicated.

(1) A person whose TB skin test is positive (ten millimeters or more induration) shall have a chest X-ray within ninety days following the skin test.

(2) A person shall not require a routine periodic retesting or X-ray (biennial or otherwise) after the entry testing.

(3) A person shall not require an entry test whose TB skin test has been documented as negative (less than ten millimeters) within the last two years, and such person shall not require a routine periodic retesting or biennial X-ray or otherwise.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-370, filed 7/21/93, effective 8/21/93.]

WAC 388-160-380 HIV/AIDS education and training. An overnight youth shelter shall provide or arrange for

appropriate education and training of employees on the prevention, transmission, and treatment of HIV and AIDS as prescribed by the department of health. Such education and training shall be consistent with the curriculum manual *KNOW-HIV/AIDS Prevention Education for Health Care Facility Employees*, January 1991, published by the Washington state HIV/AIDS program, department of health.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-380, filed 7/21/93, effective 8/21/93.]

WAC 388-160-390 Nutrition. An overnight youth shelter providing meals shall consider the age, cultural background, and nutritional requirements of youth served when preparing meals.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-390, filed 7/21/93, effective 8/21/93.]

WAC 388-160-400 Bedding. An overnight youth shelter providing youth sleeping equipment and bedding shall maintain the equipment and bedding in good repair and in a clean and sanitary manner. The shelter shall accept the use of sleeping and bedding equipment personally provided by youth in care.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-400, filed 7/21/93, effective 8/21/93.]

WAC 388-160-410 Overnight youth shelters—Purpose and limitations. The purpose of the overnight youth shelter shall be to provide youth an emergency sleeping arrangement. The overnight youth shelter shall make every effort to refer a youth to appropriate services. The overnight youth shelter providing shelter for a teen parent with child shall assure adequate quarters and services for infants and very young children. The overnight youth shelter may be licensed to provide care for either:

- (1) Children from thirteen through seventeen years of age; or
- (2) Youths sixteen through twenty years of age.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-410, filed 7/21/93, effective 8/21/93.]

WAC 388-160-420 Governing body/citizens board for overnight youth shelters. (1) Every overnight youth shelter shall have a governing body/citizens board which shall comply with all laws and rules concerning nonprofit boards of directors.

(2) The shelter facility shall keep on file a list of the current membership of the governing body citizens board.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-420, filed 7/21/93, effective 8/21/93.]

WAC 388-160-430 Intake. (1) An overnight youth shelter shall provide an intake consisting of an initial assessment of entering youth and shall include, but not be limited to:

- (a) Recent history;
- (b) Outstanding warrants;
- (c) Physical and medical needs, including medication;
- (d) Whether parents are aware of the youth's whereabouts and want the youth at home;

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- (e) School status;
- (f) Adult to contact, if one is available;
- (g) Immediate need for counseling; and
- (h) Options for the near future.

(2) The overnight youth shelter shall notify the department of social and health services (DSHS) or the police of an unaccompanied child twelve years of age or younger who is requesting service.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-430, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-430, filed 7/21/93, effective 8/21/93.]

WAC 388-160-440 Groupings. (1) The overnight youth shelter shall provide sleeping areas for males and females which are separated by partitions.

(2) In facilities caring for youths sixteen through twenty years of age, sleep areas for those sixteen and seventeen years of age shall be spatially separated from those eighteen through twenty years of age to the extent permitted by the configurations of the facility.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-440, filed 7/21/93, effective 8/21/93.]

WAC 388-160-460 Staffing. (1) An overnight youth shelter shall adhere to the following staff/child ratios:

(a) A shelter licensed for youths thirteen through seventeen years of age exclusively shall have a staff/child ratio of one staff person to every eight youth or major fraction (five or more) thereof;

(b) A shelter caring for youths sixteen through twenty years of age on the premises shall have a staff/child ratio of one staff person to every six youth or major fraction (four or more) thereof.

(2) Within the ratios in subsection (1) of this section:

(a) At least one fully trained lead counselor shall be on the premises at all times children are present; and

(b) At least one staff person shall remain awake while youths are asleep. Other staff persons may be asleep, but shall be available in the shelter in case of emergency;

(c) Whenever only one staff person is on duty, there shall be a second staff person on call.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-460, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-460, filed 7/21/93, effective 8/21/93.]

WAC 388-160-470 Supervision of youth. In an open or dormitory type setting, an overnight youth shelter staff person shall be within visual and auditory range of youths at all times when the youths are within the shelter.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-470, filed 7/21/93, effective 8/21/93.]

WAC 388-160-480 Child care workers—Qualifications. (1) All overnight youth shelter child care staff and volunteers shall:

(a) Be eighteen years of age or older. Staff twenty years of age or younger shall be under the immediate supervision of staff twenty-one years of age or older;

(b) Have completed a criminal history check;

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(c) Have completed a TB test, as required under WAC 388-73-142; and

(d) Have completed HIV/AIDS training as required under WAC 388-73-143 within sixty days of beginning employment or volunteer service at the shelter.

(2) Overnight youth shelter child care workers shall be of both sexes to reflect the population in care.

(3) One person with full training plus having one year's experience with high-risk adolescents shall be present at all times that youths are in care as described under section 500 (1) and (2) of this chapter.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-480, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-480, filed 7/21/93, effective 8/21/93.]

WAC 388-160-490 Program supervision. (1) The department shall require every overnight youth shelter to have a program supervisor.

(a) The program supervisor shall have a:

(i) Master's degree in social work or a related field and one year's experience with high-risk adolescents; or

(ii) Bachelor's degree and three years' experience with high-risk adolescents.

(b) The program supervisor shall provide two hours of supervision to youth shelter child care staff or volunteers for each forty hours that staff work.

(2) A master's degree level person with counseling experience with high-risk/troubled adolescents or a bachelor's degree level person with at least three years counseling experience with high-risk/troubled adolescents shall be on call at all times when the overnight youth shelter is open or when children are present. This person may be on staff, or on contract, or available by written agreement.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-490, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-490, filed 7/21/93, effective 8/21/93.]

WAC 388-160-500 Training. (1) All overnight youth shelter staff and volunteers shall receive training before providing care for youth. The overnight youth shelter shall ensure this training includes, but is not limited to:

(a) Job responsibilities;
 (b) Agency administration;
 (c) Supervision of youths;
 (d) Basic behavior management;
 (e) Fire safety procedures; and
 (f) Handling emergency situations.

(2) The overnight youth shelter shall ensure that staff receive training in the following areas within sixty days of beginning employment or volunteer service:

(a) AIDS/HIV;
 (b) Cultural sensitivity; and
 (c) Behavior management.

(3) New overnight youth shelter staff shall work shifts with fully trained staff until the new staff's own training has been completed.

(4) An overnight youth shelter shall offer or make available to staff and volunteers in-service training to cover policies appropriate to each position, to include supervisory skills, adolescent development and problems, and meeting

the needs of youths. The shelter's training should include, but not be limited to:

(a) Sexual abuse;
 (b) Predatory behavior;
 (c) Substance abuse;
 (d) Depression;
 (e) Mental health;
 (f) Teen suicide; and

(g) Injurious or assaultive behavior toward oneself or others.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-500, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-500, filed 7/21/93, effective 8/21/93.]

WAC 388-160-510 Services. (1) At a minimum, all overnight youth shelters shall offer the following services to all clients:

(a) Client intake including demographic information and emergency contacts (phone number), presenting problems (school status, medical problems, family situation, suicide evaluation, history of assaultive/predatory behavior, and drug/alcohol involvement);

(b) Individual crisis intervention;

(c) Assistance in accessing emergency resources, including child protective services (CPS) and emergency medical services; and

(d) Resource information;

(2) An overnight youth shelter shall provide resource information as needed for appropriate educational, vocational, placement, housing, medical, substance abuse, mental health, other treatment agencies, and food program, or to DSHS office.

(3) If appropriate ancillary services are not provided by the licensed program, the overnight youth shelter licensee shall demonstrate working relationships with organizations providing services to targeted young people.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-510, filed 7/21/93, effective 8/21/93.]

WAC 388-160-520 Client records and information—Overnight youth shelters. The overnight youth shelter shall maintain records and information concerning persons in care in such a manner as to preserve their confidentiality. The shelter shall maintain records giving the following information on each youth under care in the same shelter in which the youth is sheltered:

(1) Identifying information, including:

(a) Name;
 (b) Birth date;
 (c) Date of admission;
 (d) Ethnicity; and
 (e) Other appropriate information.

(2) Names, addresses, and telephone numbers, if any, of parents' or other persons' home or business to contact in case of emergency;

(3) Dates and kinds of illnesses and accidents, medications and treatments prescribed, the time they are given, and by whom; and

(4) Daily log of attendance, admission, referrals, exit, and important information.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-520, filed 7/21/93, effective 8/21/93.]

WAC 388-160-530 Personnel policies and records—

Overnight youth shelters. (1) Each overnight youth shelter employee and volunteer having unsupervised or regular access to the youth or child in care shall complete and submit to the licensee or director by the date of hire:

(a) An employment application on a department-prescribed form, or its equivalent; and

(b) A criminal history and background inquiry form.

(i) The licensee shall submit this form to the department for the employee and volunteer, within seven calendar days of the employee's first day of employment, permitting a criminal and background history check.

(ii) The department shall discuss the inquiry information with the licensee or director, when applicable.

(2) The overnight youth shelter licensee employing five or more persons shall have written personnel policies describing staff benefits, if any, duties, and qualifications.

(3) The overnight youth shelter licensee shall maintain a personnel recordkeeping system, having on file for the licensee, staff person, and volunteer:

(a) An employment application, including work and education history;

(b) Documentation of criminal history and background inquiry form submission;

(c) A record of a negative Mantoux, tuberculin skin tests results, X-ray, or an exemption to the skin test or X-ray;

(d) Documentation of HIV/AIDS education and training;

(e) A record of participation in staff development training;

(f) Documentation of orientation program completion;

(g) Documentation of a valid food handler permit, when applicable;

(h) Documentation of current first aid and CPR training, when applicable; and

(i) Telephone number of "on-call" master or bachelor degree level person with other emergency telephone numbers.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-530, filed 10/4/96, effective 11/4/96. Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-530, filed 7/21/93, effective 8/21/93.]

WAC 388-160-540 Reporting of death, injury, illness, epidemic, or child abuse. The overnight youth shelter licensee or staff shall report immediately:

(1) A death, serious injury requiring medical treatment, or illness requiring hospitalization of a child in care, by telephone and in writing, to the parent if contact information is known, licensor, and child's social worker, if any;

(2) An instance when the licensee or staff has reason to suspect the occurrence of physical, sexual, or emotional child abuse, neglect, or child exploitation, by telephone, to child protective services (CPS) or local law enforcement as required under chapter 26.44 RCW; and

(3) An occurrence of food poisoning or communicable disease, as required by the state board of health, by telephone, to the local public health department.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-540, filed 7/21/93, effective 8/21/93.]

(1999 Ed.)

WAC 388-160-550 Reporting runaway youth. (1) Within eight hours of learning a youth staying at the shelter is away from home without parental permission, shelter staff shall report the location of the youth to:

(a) The parent;

(b) The law enforcement agency having jurisdiction in the shelter's area; or

(c) The department.

(2) The shelter staff shall:

(a) Make the report by telephone or any other reasonable means; and

(b) Document the report in writing in the youth's file.

[Statutory Authority: RCW 74.15.030. 96-21-018, § 388-160-550, filed 10/4/96, effective 11/4/96.]

WAC 388-160-560 Reporting circumstantial changes. An overnight youth shelter's license shall be valid only for the address and organization named on the license. The overnight youth shelter licensee shall promptly report to the licensor major changes in staff, program, or premises affecting the shelter classification, delivery of safe and appropriate services, or continued eligibility for licensure. The overnight youth shelter licensee shall include as a major change:

(1) Shelter address, location, space, or phone number;

(2) Maximum number, age ranges, and sex of children the licensee wishes to serve as compared to current license specifications;

(3) Number or qualifications of the shelter's staffing pattern that may affect staff competencies to implement the specified program, including:

(a) Change in ownership, chief executive, director, or program supervisor; and

(b) The death, retirement, or incapacity of the licensee.

(4) Name of licensed corporations, or name by which the overnight youth shelter is commonly known, or changes in the shelter's articles of incorporation and bylaws;

(5) Occurrence of a fire, major structural change, or damage to the premises; and

(6) Plans for major remodeling of the shelter, including planned use of space not previously department approved.

[Statutory Authority: Chapter 74.15 RCW. 93-15-124 (Order 3541), § 388-160-560, filed 7/21/93, effective 8/21/93.]

Chapter 388-200 WAC

FINANCIAL AND MEDICAL ASSISTANCE— GENERAL PROVISIONS

WAC

388-200-1050	Department and client responsibilities.
388-200-1160	Notification of exception to rule request and decision.
388-200-1200	Translation of written communications with a limited English proficient client.
388-200-1250	Gifts, bequests by will, and contributions.
388-200-1300	Necessary supplemental accommodation services (NSA).
388-200-1350	Dispute resolution for clients needing supplemental accommodations.
388-200-1400	Application of rules—Temporary assistance to needy families.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-200-1100 Grievance procedure. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1100, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1100, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-389.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-200-1150 Exception to rule. [Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1150, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-20-010.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-200-1050 Department and client responsibilities. (1) The department and the client shall:

(a) Have a dual responsibility to determine and maintain eligibility for public assistance in the initial or redetermination of eligibility for assistance;

(b) Further, the department shall provide accommodation services to clients who have a mental, neurological, physical or sensory impairment or who otherwise have limitations which seriously affect their abilities to access programs in the same manner as those who are unimpaired.

(2) The department shall have the responsibility to:

(a) Treat a client with dignity and courtesy;

(b) Give a client sufficient opportunity to make pertinent needs and accommodation needs known to the department;

(c) Inform a client what the department can, or cannot, do for the client;

(d) Respect the rights of a client under the U.S. Constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990 and all other relevant provisions of federal and state law when:

(i) Taking an application;

(ii) Determining eligibility;

(iii) Administering financial and medical assistance programs; and

(iv) Providing accommodation to individuals who have a mental, neurological, sensory, or physical impairment.

(e) Avoid practices which violate the client's privacy or subject the client to harassment;

(f) Inform a client of:

(i) The client's rights and responsibilities concerning eligibility for, and receipt of, assistance;

(ii) All factors which may affect the client's continuing eligibility for assistance;

(iii) Changes of law or rule which affect the client's eligibility; and

(iv) His or her right to reasonable accommodations.

(g) Act promptly and correctly on all known changes which affect the client's eligibility for assistance;

(h) Offer voter registration assistance to clients during face-to-face interviews at:

(i) Application;

(ii) Eligibility review or recertification; and

(iii) Change of address.

(i) Accommodate clients per WAC 388-200-1300(7).

(3) The client has the responsibility to:

(a) Report all changes in the client's circumstances which affect eligibility for assistance. The client must report changes in writing promptly and accurately; and

(b) Take any reasonable action to develop resources which will reduce or eliminate the client's need for public assistance.

[Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1050, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.04.050 and 1993 National Voter Registration Act, SSA Sect. 402 (a)(9) and 403 (a)(3). 94-23-128 (Order 3807), § 388-200-1050, filed 11/23/94, effective 1/1/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1050, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-38-030, 388-38-250, 388-38-255 and 388-38-260.]

WAC 388-200-1160 Notification of exception to rule request and decision. The department shall notify a client in writing as well as other effective means of communication. The notification must be given within ten days of:

(1) A decision as to whether the department will initiate an exception to rule request when requested by the client; and

(2) Of the approval or denial of an exception to rule which was requested by the department.

[Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1160, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-23-387.]

WAC 388-200-1200 Translation of written communications with a limited English proficient client. The department shall fully translate the following written communications into the primary language of the limited English proficient client:

(1) A notice requesting information or action which requires a response from the client to determine:

(a) Initial eligibility; or

(b) Continuing eligibility for assistance;

(2) A notice of approval, denial, or withdrawal of an application for assistance;

(3) A notice of termination, suspension or reduction of assistance;

(4) A notice describing client rights and responsibilities;

(5) A notice requiring a client's signature or informed consent; and

(6) A notice of an overpayment of public assistance benefits.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1200, filed 5/3/94, effective 6/3/94. Formerly WAC 388-38-045.]

WAC 388-200-1250 Gifts, bequests by will, and contributions. (1) The department may accept a gift, bequest, or contributions in cash, or otherwise, from an association or corporation.

(2) The department shall not accept a gift or contribution from a person applying for, or receiving, public assistance.

(3) The department shall not advise any person desiring information or assistance regarding the preparation of a will. The department shall advise the person to contact an attorney, or the local legal aid society.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-200-1250, filed 5/3/94, effective 6/3/94.]

WAC 388-200-1300 Necessary supplemental accommodation services (NSA). (1) "NSA clients" are individuals, who have a mental, neurological, physical or sensory impairment or who otherwise have limitations which seriously affect their abilities to access programs in the same manner as those who are unimpaired.

(2) All department staff have a continuing responsibility to identify and assist NSA clients. Also see, WAC 388-200-1050 (2)(b), and WAC 388-200-1050 (2)(d)(iv), regarding client rights to self-identification and accommodation.

(3) The department shall screen all applicants with whom its staff come into direct contact in order to identify NSA clients.

(a) The department shall provide an explanation of NSA services to all clients upon initiation of the NSA screening.

(b) The department shall initially identify all individuals included in subsections (i) and (ii) below as NSA, unless the client declines NSA services.

(i) Clients who identify themselves as requiring NSA services in order to access the department's services and programs.

(ii) Clients in the following categories:

(A) Identified as having or claiming to have a mental health impairment;

(B) Having a developmental disability;

(C) Disabled by drug addiction or alcoholism;

(D) Unable to read or write in any language;

(E) A minor not residing with parents.

(c) The department shall initially identify as NSA all individuals who are observed to have cognitive limitations, regardless of the presence or absence of an underlying disability, which are likely to prevent them from understanding the nature of NSA services and affect their ability to access department programs.

Cognitive limitations include limitations on ability to communicate, understand, remember, process information, exercise judgement and make decisions, perform routine tasks or relate appropriately with others.

(4) The department shall mark all cases identified as NSA with a uniform NSA identifier.

(5) Clients initially identified as NSA under subsection (3)(b)(ii) and (c) above will be assessed to confirm the NSA designation.

(6) Based on client request or changes in the client's needs, the NSA designation and/or accommodation plan may be assessed and revised.

(7) An accommodation plan which specifies the auxiliary aids and services to be provided the client to improve the client's access to department programs and services will be developed for clients determined NSA.

(8) The following NSA services shall be included in the accommodation plan of clients determined NSA under subsections (3)(b)(ii) and (c) above.

(a) Arranging for or providing assistance with completion and submission of forms;

(b) Assisting in obtaining information necessary to determine eligibility or to maintain current benefits;

(c) Explaining the department's adverse actions, see WAC 388-245-1000;

(d) Assisting with requests for fair hearings;

(e) Assisting with requests for continuing benefits;

(f) Providing follow-up contact on missed appointments or deadlines;

(g) Providing notification to the NSA individual's known advocate when informational requests or adverse action notices are pending;

(h) Providing protective payments as appropriate, in accordance with WAC 388-265-1250 (3) and (6).

(9) The department shall redirect and hold warrants for NSA clients through the twentieth day of the month following the month that adverse action notice was given, when the department is unable to determine eligibility. If eligibility is determined within the twenty-day period, the department will release to the client the correct grant amount the client would have been eligible to receive for the month in which redirection occurred. See WAC 388-245-1350;

(10) The department shall consider the effects of the NSA client's limitation or impairment on the client's ability to: accept or pursue required medical treatment, accept or pursue referrals to other agencies, provide timely monthly income reports, voluntarily quit employment, participate in food stamp employment and training, or participate in the job opportunities and basic skills (JOBS) program. The department shall find the client has good cause for refusal or failure to comply with these requirements and shall take no adverse action when the effects of the client's limitation or impairment substantially contributed to the client's noncompliance.

[Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1300, filed 12/30/96, effective 1/30/97.]

WAC 388-200-1350 Dispute resolution for clients needing supplemental accommodations. (1) An applicant or recipient has the right to file a grievance with the department in accordance with the grievance procedures provided in WAC 388-200-1100, regarding any aspect of NSA services. The department shall offer to assist a client who expresses dissatisfaction with NSA services with filing and pursuing a grievance.

(2) Department decisions as to NSA designations, accommodation plans or NSA services do not in themselves provide a basis for a fair hearing until the client has first completed the grievance process. This provision does not limit the client's rights to raise NSA designations, accommodation plans and NSA services in a fair hearing where they are relevant to other issues which are the subject of the fair hearing.

(3) Failure to follow NSA requirements does not in itself invalidate department actions, except where the applicant or recipient was denied benefits for which he/she could have established eligibility had the department followed NSA requirements.

(4) The department shall review the decision to terminate, suspend or reduce financial assistance to NSA recipients upon request. The department shall reinstate financial assistance for those months for which the department can determine that the client met program eligibility requirements and the adverse action:

(a) Was taken because of the client's failure to comply with a department requirement;

(b) The failure to comply was substantially related to the client's impairment; and

(c) Was taken no more than ninety days prior to the request.

(5) The department may reinstate assistance when the adverse action was taken more than ninety days prior to the request where administratively feasible and not prohibited by state or federal law.

[Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-200-1350, filed 12/30/96, effective 1/30/97.]

WAC 388-200-1400 Application of rules—Temporary assistance to needy families. Unless otherwise specified, references in Title 388 WAC to the aid to families with dependent children (AFDC) program shall include the temporary assistance to needy families (TANF) program.

[Statutory Authority: RCW 74.08.090, 74.04.050, 70.04.055 and Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, § 103). 97-07-008, § 388-200-1400, filed 3/10/97, effective 4/10/97.]

Chapter 388-222 WAC DIVERSION ASSISTANCE

WAC

388-222-001	Definitions.
388-222-010	Diversion cash assistance (DCA).
388-222-020	Diversion cash assistance payments.

WAC 388-222-001 Definitions. "Adult." Any person age eighteen or older.

"Bona fide need." An actual, established need a family has for living expenses.

"Crisis." A family situation that the family can take care of if they receive help with one or more bona fide needs as defined in this chapter.

"DCA benefit begin date/month." The date/month of application or the date/month in which TANF or SFA eligibility exists if the applicant is not TANF or SFA eligible in the application month.

"Diversion assistance." The array of government and community services and resources, including diversion cash assistance (DCA), that is available to help some low income families so that the family does not have to go on temporary assistance for needy families (TANF) or state family assistance (SFA).

"Diversion cash assistance." A state-funded program that can provide up to fifteen hundred dollars of brief emergency money to TANF or SFA eligible families who are in crisis and have a bona fide need(s).

"Family." At least one TANF or SFA eligible adult(s), any other people who must be included with that adult(s) in one TANF or SFA assistance unit, and any caretaker adult(s) who would be included in the TANF or SFA assistance unit but is ineligible because of TANF disqualification, citizenship status or any other reason.

"Unsubsidized job." A job in which the government does not give the employer any money to help pay the wage or salary of the person who has the job.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 97-20-124, § 388-222-001, filed 10/1/97, effective 11/1/97.]

WAC 388-222-010 Diversion cash assistance (DCA). To get DCA, the family has to:

(1) Meet all the eligibility rules for TANF or SFA that are in chapters 388-215, 388-216, 388-217, and 388-218 WAC except:

(a) The family does not have to meet the TANF or SFA work requirements that are in chapter 388-310 WAC; and

(b) The family does not have to meet the child support rules, including cooperating with division of child support, that are in WAC 388-215-1400 through 388-215-1490; and

(c) TANF or SFA recipients who are terminated and who apply for DCA within thirty days of termination are treated as applicants; and

(d) After the family is determined eligible for DCA their countable income and resources will not be used to decide how much DCA the family can receive.

(2) Meet all the other eligibility requirements of DCA including:

(a) The family must be in crisis as defined in this chapter;

(b) The family must have a bona fide need. Bona fide needs include, but are not limited to:

(i) Child care bills;

(ii) Rent payments;

(iii) Transportation costs;

(iv) Food costs, unless an adult member of the family has been disqualified for food stamps;

(v) Medical costs, unless an adult member is not eligible because of noncooperation with third party liability (TPL) requirements; or

(vi) Money needed to get or keep an unsubsidized job.

(c) The family must provide proof that the bona fide needs exist;

(d) The amount of DCA the family receives can not be more than the cost of the bona fide need(s) and must keep the family from going on TANF;

(e) The family has to have, or be likely to get, enough income or other resources that a reasonable person could expect the family to support themselves for at least twelve months.

(3) All money, except TANF and SFA, and all services which the federal government pays for, that can be used to meet the family's crisis, should be used before DCA is used.

(4) A family cannot get DCA if:

(a) Any adult member of the family is ineligible for TANF or SFA due to disqualification, drug conviction, lump sum income rule, or any other reason, except receipt of Supplemental Security Income (SSI);

(b) All adult family members are ineligible for TANF or SFA due to receipt of SSI; or

(c) Any adult member has received TANF/SFA in the current DCA benefit month or has received DCA within the past twelve months.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 97-20-124, § 388-222-010, filed 10/1/97, effective 11/1/97.]

WAC 388-222-020 Diversion cash assistance payments. (1) When all other DCA eligibility requirements are met, an assistance unit can get DCA payment for bona fide needs that occur prior to or during the thirty-day period following the benefit begin date.

(2) DCA will be paid directly to vendor(s) whenever possible.

(3) If a DCA adult recipient reapplies for TANF or SFA:

(a) Eligibility is determined without regard to the DCA payment if twelve months or more have gone by since the DCA benefit month.

(b) A DCA loan is established if fewer than twelve months have gone by since the DCA benefit month. The DCA loan is one-twelfth of the DCA received multiplied by the number of months that are left before the twelve months have gone by.

(4) The DCA loan has to be repaid having five percent of the TANF or SFA grant taken out of the TANF or SFA check each month.

(5) DSHS collects back the DCA loan solely by grant deduction.

(6) If the adult(s) who has to pay the loan goes off TANF or SFA before the loan is repaid, collection of the loan is suspended unless the adult(s) goes back on TANF or SFA. If the family goes back on TANF or SFA collection of the loan is resumed.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 97-20-124, § 388-222-020, filed 10/1/97, effective 11/1/97.]

Chapter 388-235 WAC GENERAL ASSISTANCE UNEMPLOYABLE

WAC

388-235-1500	Persons in institutions.
388-235-5000	Incapacity determination—Process.
388-235-5050	Waiver of medical documentation and progressive evaluation process (PEP).
388-235-5060	Determination of capacity to engage in gainful employment.
388-235-5070	Sources of medical evidence.
388-235-5080	Medical evidence requirements.
388-235-5090	Assigning severity ratings.
388-235-5100	PEP step I—Review of medical documentation.
388-235-5200	PEP step II—Severity of mental impairments.
388-235-5300	PEP step III—Severity of physical impairments.
388-235-5400	Progressive evaluation process—Step IV—Multiple impairments.
388-235-5500	Progressive evaluation process—Step V—Functional mental capacity.
388-235-5600	Progressive evaluation process—Step V—Functional physical capacity.
388-235-5700	Evaluating vocational factors for progressive evaluation process—Steps VI and VII.
388-235-5800	Progressive evaluation process—Step VI—Evaluate capacity to perform past work.
388-235-5900	Progressive evaluation process—Step VII—Evaluating capacity to perform other work.
388-235-6000	Duration of assistance based on incapacity.
388-235-7000	Purpose of referrals.
388-235-7100	Treatment and referral requirements.
388-235-7200	Other agency referral requirements.
388-235-7300	ADATSA referral requirements.
388-235-7400	Protective payments.
388-235-7500	Good cause for refusing medical treatment or other agency referrals.
388-235-7600	Sanction for refusing medical treatment or other agency referrals.
388-235-8000	Redetermination of financial eligibility.
388-235-8100	Redetermination of incapacity.
388-235-8130	Determining a recipient is no longer incapacitated—Termination proviso.
388-235-8140	Redetermination of eligibility based on mental retardation.
388-235-8150	Redetermination for a recipient appearing to meet federal disability criteria for SSI.
388-235-8200	Reinstating eligibility after termination due to lack of medical evidence.
388-235-9000	Benefits from other programs.

(1999 Ed.)

388-235-9100
388-235-9200
388-235-9300

GAU pending SSI eligibility.
Assignment and recovery of interim assistance.
GAU to an SSI recipient whose SSI check is lost, stolen, or missent.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-235-0010	Purpose of program. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-0010, filed 7/29/93, effective 8/29/93.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Definitions. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-0020, filed 7/29/93, effective 8/29/93.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-0020	Summary of eligibility conditions. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-0030, filed 7/29/93, effective 8/29/93.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-0030	Assistance unit. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-0040, filed 7/29/93, effective 8/29/93.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-0040	Age requirements. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-0050, filed 7/29/93, effective 8/29/93. Formerly WAC 388-26-025 (part.)] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-0050	Residence—Establishing. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-0060, filed 7/29/93, effective 8/29/93. Formerly parts of WAC 388-26-050 and 388-26-055.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-0060	Residence—Temporary absences. [Statutory Authority: RCW 74.08.090. 94-16-044 (Order 3759), § 388-235-0070, filed 7/27/94, effective 9/1/94; 93-16-058 (Order 3559), § 388-235-0070, filed 7/29/93, effective 8/29/93. Formerly WAC 388-26-060 (part.)] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-0070	Residence—Applicant living in another state. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-0080, filed 7/29/93, effective 8/29/93. Formerly WAC 388-26-065.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-0080	Residence—Applicant receiving assistance from another state. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-0090, filed 7/29/93, effective 8/29/93. Formerly WAC 388-26-070 (part.)] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-0090	Citizenship and alien status. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-0100, filed 7/29/93, effective 8/29/93. Formerly WAC 388-26-120 (part.)] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-0100	Social Security number. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-0110, filed 7/29/93, effective 8/29/93.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-0110	Resources. [Statutory Authority: RCW 74.08.090 and 1997 c 58 § 307. 97-20-128, § 388-235-2000, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.08.090. 94-16-044 (Order 3759), § 388-235-2000, filed 7/27/94, effective 9/1/94; 93-16-058 (Order 3559), § 388-235-2000, filed 7/29/93, effective 8/29/93.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-235-2000	Income. [Statutory Authority: RCW 74.08.090. 94-16-044 (Order 3759), § 388-235-3000, filed 7/27/94, effective 9/1/94; 93-16-058 (Order 3559), § 388-235-3000,
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388-235-4000 filed 7/29/93, effective 8/29/93.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
 GAU payment and need standards. [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-4000, filed 7/29/93, effective 8/29/93.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-235-1500 Persons in institutions. (1) If otherwise eligible for GAU, a person in an institution may be granted general assistance if the person is not:

- (a) An inmate of a public institution; or
- (b) A patient of a public institution unless in a medical institution; or
- (c) A patient of a public institution unless in an institution for mental disease and is:
 - (i) Sixty-five years of age or over; or
 - (ii) Twenty years of age or younger.

(2) If a person has been committed to the confinement and custody of a public institution such as a state penitentiary or county jail, the department shall consider the person an inmate of the public institution if he or she is:

- (a) On a work release program; or
- (b) Confined to a place of residence other than the institution.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-1500, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5000 Incapacity determination—Process. (1) When determining whether incapacity exists, the department shall consider only the person's ability to obtain and perform work-related activity.

(2) Unless medical documentation requirements are waived under WAC 388-235-5050, the department shall:

- (a) Determine the existence, severity, and duration of a person's incapacity for the GAU program using PEP; and
- (b) Apply each step of this process sequentially, using as many steps as necessary to reach a decision as to whether incapacity exists.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5000, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5050 Waiver of medical documentation and progressive evaluation process (PEP). The department shall consider incapacity established without medical documentation and a progressive evaluation process (PEP) when a person is:

- (1) Eligible for a financial benefit based on Social Security Administration disability criteria;
- (2) Eligible for services from the division of developmental disabilities;
- (3) Sixty-five years of age or older;
- (4) Released from inpatient psychiatric treatment and is participating in direct treatment services to meet the client's mental health needs. In such cases:
 - (a) The department shall establish a person's incapacity for ninety days without a psychiatric/psychological evaluation; or

(b) The department shall not establish a person's incapacity if the client leaves ongoing inpatient psychiatric treatment against medical advice.

(5) Eligible for long-term care services administered by the aging and adult services administration of the department directly or through contract with area agencies on aging; or

(6) Released from aging and adult services administered long-term care services in a medical institution. In such cases, incapacity shall be established for ninety days from the date of release.

[Statutory Authority: RCW 74.08.090. 96-16-022, § 388-235-5050, filed 7/30/96, effective 8/30/96; 93-16-058 (Order 3559), § 388-235-5050, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5060 Determination of capacity to engage in gainful employment. (1) The department shall determine a person's ability to perform gainful employment when:

(a) Determining eligibility. The department may waive the determination of gainful employment if medical documentation requirements are waived under WAC 388-235-5050;

(b) The person is employed; or

(c) New information is received which may indicate employability.

(2) The department shall consider the ability to perform gainful employment as the capacity to perform, in a regular and predictable manner, an activity usually done for pay or profit. Gainful employment does not include:

(a) Working under special conditions, such as in a department-approved sheltered workshop; or

(b) Working sporadically or part-time if, due to the incapacity, the person is unable to compete with unimpaired workers in the same job.

(3) The department shall deny or terminate general assistance to a person capable of or engaged in gainful employment.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5060, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5070 Sources of medical evidence. (1) The department shall pay the cost of necessary medical reports to determine incapacity except when the reports are provided by DSHS personnel.

(2) For a physiological impairment, the department shall only accept as primary evidence reports from the following medical professionals:

(a) A physician;

(b) An advanced registered nurse practitioner (ARNP) in the ARNP's area of certification; or

(c) The chief of medical administration of the Veterans' Administration, or their designee, as authorized in federal law.

(3) For an emotional or mental impairment, the department shall only accept as primary evidence reports from:

(a) A psychiatrist;

(b) A licensed clinical psychologist;

(c) An advanced registered nurse practitioner when certified in psychiatric nursing;

(d) A mental health professional designated by the local community mental health agency, as defined under RCW 71.05.020; or

(e) A physician, at the department's discretion.

(4) For a claimed or apparent developmental disability, the department may accept as primary evidence reports from a medical professional skilled in identifying developmental disabilities.

(5) The department shall accept as supplemental medical evidence reports from:

(a) Treating practitioners, such as a chiropractor, nurse, or physician's assistant; or

(b) DSHS institutions and agencies which are providing or have provided services to the person.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5070, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5080 Medical evidence requirements.

(1) The department shall only accept written medical evidence containing clear, objective medical documentation which includes:

(a) A diagnosis for the incapacitating conditions;

(b) The effect of the condition on the individual's ability to perform work-related activities; and

(c) Relevant medical history and sufficient medical documentation to support any conclusions of incapacity.

(2) When making an incapacity decision, the department shall not place significant weight on an individual's report of symptoms unless medical findings show that a medical condition is present that could reasonably be expected to produce the symptoms which are reported. In such cases, clear, objective medical information must be present, including professional observation and relevant medical history, which supports conclusions about:

(a) The existence and persistence of the symptom(s); and

(b) Its effect on the individual's ability to function.

(3) The department shall consider the opinion of the treating or consulting physicians or health care professionals when determining a person's incapacity. The department shall set forth clear and convincing reasons for rejecting uncontradicted medical opinion in making an incapacity decision.

(4) The determination of incapacity shall be made solely by the department based on the medical information received. The department shall not be bound by decisions of incapacity or unemployability made by another agency or person.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5080, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5090 Assigning severity ratings. The department shall assign severity ratings on a scale of one to five including a severity rating of:

(1) "One" when a person's impairment has no effect on the performance of basic work-related activities;

(2) "Two" when a person's impairment has no significant effect on performance of basic work-related activities;

(3) "Three" when a person's impairment significantly limits performance of at least one basic work-related activity;

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(4) "Four" when a person's impairment very significantly limits performance of at least one basic work-related activity; and

(5) "Five" when a person's impairment prevents the performance of at least one basic work-related activity.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5090, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5100 PEP step I—Review of medical documentation. (1) The department shall review a person's medical documentation to ensure the following requirements are met:

(a) The medical report contains sufficient information as described under WAC 388-235-5070;

(b) An authorized medical professional wrote the medical report;

(c) The medical report documents the existence of a potentially incapacitating condition; and

(d) The medical report indicates an impairment is expected to last ninety days or more from the application date.

(2) The department may require additional medical information when the information received is insufficient to decide incapacity.

(3) The department shall deny a person's application when:

(a) There is a single impairment with objective findings consistent with a severity rating less than "three"; or

(b) A reported impairment is not expected to last ninety days or more (or twelve weeks) from the date of application.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5100, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5200 PEP step II—Severity of mental impairments. (1) If a mental impairment is claimed, the department shall determine severity of the person's mental or emotional disorder based on:

(a) Psychosocial and treatment history;

(b) Clinical findings;

(c) Results of special tests; and

(d) Professionally observed symptomatology that indicates impairment of the person's ability to perform basic work-related activities.

(2) For a person diagnosed as mentally retarded, the department shall assign a person's severity rating based on:

(a) A full test intelligence quotient (IQ) score. The department shall consider a person's IQ score of:

(i) Eighty-five or above within normal limits and is rated "one";

(ii) Seventy to eighty-four as borderline intellectual functioning and is rated "three";

(iii) Sixty-nine or below as mental retardation and is rated "five"; or

(b) The lowest IQ subscale score, for example, verbal or performance, rated as described under subsection (2)(a) of this section when:

(i) The full IQ test could not be given; and

(ii) At least two subscale scores are provided.

(3) For a person diagnosed as having an organic mental disorder, the department shall assign a severity rating based

on the most severe of the following three areas of a person's impairment:

- (a) Marked memory defect for recent events;
- (b) Impoverished, slowed, perseverative thinking, with confusion or disorientation; or
- (c) Labile, shallow, or coarse affect.

(4) The department shall base the severity of a person's functional psychotic or nonpsychotic disorder, excluding alcoholism or drug addiction, on:

(a) Clinical assessment of these twelve symptoms: Depressed mood, suicidal trends, verbal expression of anxiety or fear, expression of anger, social withdrawal, motor agitation, motor retardation, paranoid behavior, hallucinations, thought disorder, hyperactivity, preoccupation with physical complaints; and

- (b) An overall assessment of:

(i) Intensity and pervasiveness of the symptoms as described under subsection (4)(a) of this section; and

(ii) Effect on the client's ability to perform work-related activities.

(c) The department shall assign a minimum severity rating of "three" when one or more of the person's symptoms, as described under subsection (4)(a) of this section is present and one or more of the following conditions are met:

- (i) A diagnosis of psychotic disorder has been made;

(ii) The person has been hospitalized for psychiatric reasons two or more times within the preceding two years;

(iii) The person has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration within the preceding two years;

(iv) The person is considered at least moderately impaired by at least three of the above-listed symptoms; or

(v) The person is considered as at least moderately impaired in the overall assessment of intensity and pervasiveness of these symptoms.

(d) The department shall assign a minimum rating of "four" when the overall assessment of the intensity and pervasiveness of these symptoms is:

- (i) Marked; or

(ii) Moderate and three or more of the above symptoms are present to at least a marked degree.

(e) The department shall assign a rating of "five" when the overall assessment of the intensity and pervasiveness of these symptoms is:

- (i) Severe; or

(ii) Marked and three or more of the above symptoms are present to a severe degree.

(5) When a person is diagnosed as being impaired in more than one area, the department shall assign one mental rating based on ratings in each of the three areas:

(a) A person with two or more moderate impairments or one or more moderate and one marked impairment is considered to have an overall mental severity rating of "four";

(b) A person with two or more marked impairments is considered to have an overall mental severity rating of "five."

(6) When the overall functioning level appears consistent with the person's overall mental severity rating, the department shall:

(a) Deny GAU when the person does not have a significant claimed physical impairment and an overall mental severity rating of "one" or "two";

(b) Approve GAU when the person has an overall mental severity rating of "five," regardless of whether a significant claimed physical impairment exists; or

(c) Evaluate the person at the next applicable step, when the person:

(i) Has an overall mental severity rating of "three" or "four"; or

(ii) Has a mental severity rating of "two" and also has a physical impairment.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5200, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5300 PEP step III—Severity of physical impairments. (1) When a person claims a physical impairment, the department shall determine the severity rating of the person's physical impairment based on current medical evidence that provides an objective description of the impairment.

(2) The department shall assign a severity rating for each diagnosed physical impairment:

(a) The department shall use the examining medical evidence provider's given severity rating when:

(i) The given rating is substantiated by and consistent with the medical evidence provided;

(ii) The medical evidence provider's assessment of functional capacities is consistent with the department's definition of the given severity rating; and

(iii) The medical evidence provider's given severity rating is not contradicted by:

(A) Other evidence from the same evaluation; or

(B) By evidence from a separate, current evaluation of the client.

(b) The department shall assign a severity rating by comparing the medical findings of the client's functional capacities with the severity rating definitions when:

(i) The medical evidence provider fails to assign a severity rating; or

(ii) The rating does not meet the conditions under subsection (2)(a) of this section.

(3) After assigning a severity rating to each physical impairment, the department shall:

(a) Deny GAU when the person does not have a diagnosed mental impairment rated "two" or more and only one physical impairment consistent with a severity rating of "two";

(b) Approve GAU if the person's physical impairment is consistent with a severity rating of "five"; or

(c) Evaluate the person at "step 4" when the person

(i) Has a multiple physical impairment rated "two," "three," or "four"; or

(ii) Has both physical and mental impairment ratings of at least "two."

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5300, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5400 Progressive evaluation process—Step IV—Multiple impairments. (1) When a person

has two or more diagnosed impairments and each impairment is consistent with a severity rating of "two" or more but none are consistent with a severity rating of "five," the department shall:

(a) Assign an overall severity rating; and

(b) Classify each diagnosis according to body system based upon the International Classification of Diseases (ICD), 9th revision.

(2) The department shall disregard severity ratings assigned to a person's alcoholism or drug addiction in this process.

(3) When a person's diagnosed impairments are all classified under the same body system, the department shall assign an overall severity rating for the person by:

(a) Using the highest rating given by the medical evidence provider to an impairment within that system; or

(b) When all impairments are rated "two," raising the severity rating to "three" when the impairments have the cumulative effect of significantly interfering with one or more basic work-related activity.

(4) When all diagnosed impairments, including mental disorders, are classified under at least two body systems, the department shall assign an overall severity rating by combining the highest rating from each body system. The department shall:

(a) Assign an overall severity rating of "four" when there are two or more impairments with severity ratings of "three" or one or more impairment has a severity rating of "three" and one impairment has a severity rating of "four";

(b) Assign an overall severity rating of "five" when there are two or more impairments with severity ratings of "four";

(c) Assign an overall severity rating of "three" only when:

(i) There are two or more impairments;

(ii) No impairments are rated higher than "two"; and

(iii) The impairments have the cumulative effect of significantly interfering with one or more basic work-related activities.

(5) When an overall severity rating is assigned, the department shall:

(a) Deny GAU if the impairments are consistent with an overall severity rating of "two"; or

(b) Approve GAU if the impairments have an overall severity rating of "five"; or

(c) Evaluate the person at the next step.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5400, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5500 Progressive evaluation process—Step V—Functional mental capacity. (1) The department shall evaluate the functional capacity of a person with mental impairments assigned an overall severity rating of "three" or "four" by assessing the person's specific cognitive and social factors.

(2) The department shall evaluate cognitive factors by assessing a person's abilities to:

(a) Understand, remember, and follow simple, one-or-two step instructions;

(b) Understand, remember, and follow complex instructions, with three or more steps;

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(c) Learn new tasks;

(d) Exercise judgment and make decisions; and

(e) Perform routine tasks without undue supervision.

(3) The department shall approve GAU when the clinical assessment indicates the person:

(a) Is at least moderately impaired in their ability to understand, remember, and follow simple, one-or-two step instructions and is at least moderately limited in their ability to:

(i) Learn new tasks, exercise judgment, and make decisions; and

(ii) Perform routine tasks without undue supervision; or

(b) Can understand, remember, and follow simple instructions, but is:

(i) At least moderately impaired in their ability to understand, remember, and follow complex instructions, with three or more steps; and

(ii) Markedly limited in the ability to learn new tasks, exercise judgment and make decisions, and perform routine tasks without undue supervision.

(4) The department shall evaluate a person's social factors by assessing the person's abilities to:

(a) Relate appropriately to coworkers and supervisors;

(b) Interact appropriately in public contacts;

(c) Tolerate the pressures of a work setting;

(d) Care for self, including personal hygiene; and

(e) Maintain appropriate behavior in a work setting.

(5) The department shall:

(a) Assess the limitations on the person's social functioning indicated by the medical evidence provider; and

(b) Approve GAU if a combination of significant limitations exists in the area of social functioning that precludes gainful employment.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5500, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5600 Progressive evaluation process—Step V—Functional physical capacity. (1) The department shall consider the effect of a person's physical impairment on the ability to perform work-related activities when a person's physical impairments are assigned an overall severity rating of "three" or "four."

(a) The department shall assess physical functional capacity based on the person's exertional, exertionally-related and nonexertional limitations.

(b) For the department to consider a limitation, the limitation must be substantiated by the medical evidence and directly related to the diagnosed impairment(s).

(2) The department shall assign an exertion level and determine a person's exertionally-related limitations by comparing all available medical evidence to the definitions of exertional levels, exertionally-related limitations and nonexertional limitations under WAC 388-235-5020 when:

(a) The medical evidence provider does not document that a person's diagnosed impairment causes a limitation on work-related activities; or

(b) A given limitation is not consistent with objective medical evidence.

(3) "Exertion level" means a comparison of a person's capacity to lift, carry, stand and walk with the strength

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needed to fulfill job duties in the following work categories. For this subsection, occasionally means less than one-third of the time and frequently means one-third to two-thirds of the time:

(a) Sedentary: A person is in this category when capable of lifting ten pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are only required occasionally and other sedentary criteria are met.

(b) Light: A person is in this category when capable of lifting twenty pounds maximum with frequent lifting and/or carrying of objects weighing up to ten pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

(c) Medium: A person is in this category when capable of lifting fifty pounds maximum with frequent lifting and/or carrying of objects weighing up to twenty-five pounds.

(d) Heavy: A person is in this category when capable of lifting one hundred pounds maximum with frequent lifting and/or carrying of objects weighing up to fifty pounds.

(4) "Externally-related limitations" means a restriction in mobility, agility or flexibility in the following twelve activities: Balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping.

(5) "Nonexertional physical limitations" means restrictions on work activities that do not affect strength, mobility, agility, or flexation.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5600, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5700 Evaluating vocational factors for progressive evaluation process—Steps VI and VII. (1) The department shall consider vocational factors of age, education, and work experience only when a person's impairment(s) have been assigned an overall severity rating of an "three" or "four."

(2) The department shall evaluate education in terms of formal schooling or other training which enables a person to meet job requirements. The department shall classify a person's education as:

(a) "Illiterate" when a person is able to sign their name, but cannot read or write a simple communication, such as instructions, or inventory lists;

(b) "Limited education" when a person has completed formal education of the eleventh grade level or less or special education, unless there is evidence to the contrary; or

(c) "High school education and above" when a person has completed high school or obtained a general education equivalency degree (GED) and is capable of work at a semi-skilled through skilled job level, unless there is evidence to the contrary.

(3) The department shall evaluate a person's work experience to determine if it constitutes relevant past work. Relevant past work is defined as work:

(a) Normally done for pay or profit. Noncompetitive work, like working in a sheltered workshop, jobs where the impaired worker was given special consideration, or the regular activities of a student or homemaker, is excluded;

(b) Performed in the past five years; and

(c) Done long enough for the person to acquire the skills to continue doing the job, considering the reasons for losing or frequently changing jobs or the specific skills or nature of the job. If the job is not excluded based on such considerations, the department shall consider the person to have the necessary work skills when the following minimum cumulative time periods are met:

(i) Thirty days for unskilled work;

(ii) Three months for semi-skilled work; and

(iii) Six months for skilled work.

(4) The department shall evaluate a person with relevant work experience and determine whether the person has transferrable skills. The department shall compare the person's description of the relevant work with the general work requirements for jobs in the following occupational areas:

(a) Managerial and administrative;

(b) Professional, paraprofessional, and technical;

(c) Sales;

(d) Clerical and administrative support;

(e) Service;

(f) Agriculture, forestry, and fishing; and

(g) Production, construction, maintenance, and material moving.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-5700, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5800 Progressive evaluation process—Step VI—Evaluate capacity to perform past work.

(1) The department shall evaluate a person's ability to perform relevant past work in relation to current functional capacities before considering the person's age and educational factors.

(2) For each job the department considers part of the person's relevant work experience, the department shall determine:

(a) The exertional or skill requirements of the job; and

(b) Current cognitive, social, or nonexertional factors that significantly limit the person's ability to perform relevant past work.

(3) After evaluating a person's relevant past work experience, the department shall:

(a) Deny GAU when a person has:

(i) The physical or mental ability to perform past relevant work and a significant cognitive, social or nonexertional limitation does not exist; or

(ii) Recently acquired specific work skills through successful completion of vocational training enabling the person to work within current physical or mental capacities;

(b) Approve GAU when the person:

(i) Is fifty-five years of age or older; and

(ii) Has an impairment that is assigned an overall severity rating of at least "three"; and

(iii) Does not have the physical or mental ability to perform relevant past work or does not have relevant past work; or

(c) Evaluate the person at the next step.

[Statutory Authority: RCW 74.08.090, 93-16-058 (Order 3559), § 388-235-5800, filed 7/29/93, effective 8/29/93.]

WAC 388-235-5900 Progressive evaluation process—Step VII—Evaluating capacity to perform other work. (1) If a person is unable to perform past work, the department shall evaluate a person's ability to perform other work.

(2) The department shall approve GAU for a person who has a significant physical limitation and is limited to:

(a) Sedentary work; or

(b) Light work, and the person is:

(i) Fifty years of age or older;

(ii) Thirty-five years of age or older and cannot speak, read, or write English; or

(iii) Eighteen years of age or older and has a limited education or less and no relevant past work.

(c) Medium work, and the person is:

(i) Fifty years of age or older and has a limited education or less and no relevant past work; or

(ii) Fifty-five years of age or older without consideration of educational level or other work limitations.

(d) Heavy work with only nonexertional limitations and fifty-five years of age or older.

(3) The department shall approve GAU when a person is in the following age ranges and has the described cognitive or social limitations on a functional mental capacity:

(a) Fifty years of age or older with a:

(i) Moderate limitation on the ability to relate appropriately to coworkers and supervisors; and

(ii) Marked limitation on the ability to respond appropriately to, and tolerate the pressures and expectations of, a normal work setting.

(b) Eighteen to fifty-four years of age with a severe limitation on the ability to respond appropriately to, and tolerate the pressures and expectations of, a normal work setting; or

(c) Eighteen to forty-nine years of age and has:

(i) A severity rating of "four" and one or more of the twelve symptoms identified in WAC 388-235-5200 (4)(a) listed as "severe"; and

(ii) "Moderate" limitation in the ability to relate appropriately to coworkers and supervisors; and

(iii) "Marked" limitation in the ability to respond appropriately to, and tolerate the pressures and expectations of, a normal work setting.

(4) The department shall approve GAU when a person has both a significant mental impairment and a significant physical impairment and:

(a) Either impairment meets the criteria in subsection (2) or (3) of this section; or

(b) The person meets the criteria in subsection (3)(a) of this section when age is disregarded; or

(c) After disregarding relevant past work experience, a person with limited education or less is:

(i) Fifty years of age or older and work activities are restricted to medium exertional level or less; or

(ii) Eighteen to forty-nine years of age and their work activities are restricted to light exertional level.

(5) The department shall approve or deny eligibility for GAU by administrative review for any person not eligible for GAU using the criteria in subsection (2), (3), or (4) of this section.

(a) A team of two or more department designees shall conduct the administrative review; and

(b) The administrative review team shall decide incapacity by assessing, independent of the progressive evaluation process, all available medical information and identified vocational factors, including transferable skills, for effects on the person's ability to do work-related activities.

[Statutory Authority: RCW 74.08.090, 93-16-058 (Order 3559), § 388-235-5900, filed 7/29/93, effective 8/29/93.]

WAC 388-235-6000 Duration of assistance based on incapacity. (1) The department shall determine the duration of a person's incapacity based on the department's evaluation of the medical evidence and other relevant information in the case record.

(2) The department shall establish the duration of assistance based on a person's incapacity. The duration shall not exceed twelve months without a redetermination of the incapacity.

[Statutory Authority: RCW 74.08.090, 93-16-058 (Order 3559), § 388-235-6000, filed 7/29/93, effective 8/29/93.]

WAC 388-235-7000 Purpose of referrals. The purpose of treatment or other agency referrals is to:

(1) Restore or improve the person's ability to work for pay in a regular and predictable manner;

(2) Reduce the person's need for general assistance.

[Statutory Authority: RCW 74.08.090, 93-16-058 (Order 3559), § 388-235-7000, filed 7/29/93, effective 8/29/93.]

WAC 388-235-7100 Treatment and referral requirements. (1) For GAU eligibility, an incapacitated person shall accept and follow through on required available medical treatment, which is reasonably expected to render the person able to work, unless there is good cause for failure to do so.

(2) The department shall provide written notification of a person's treatment requirements at the time of initial approval and at each redetermination.

(3) The department shall recommend available medical services, provided under the state-financed medical care services program.

(4) The department shall assess and decide if a person needs to be referred to treatment, referred to other agencies, or other social services. After the initial assessment, the department will assess the person's treatment and social services needs once a year or more often.

(5) When a client fails or refuses treatment, referral to other agencies, or other social services, the department shall make the "good cause" determination based on criteria in WAC 388-235-7500.

(6) Any recipient disagreeing with treatment requirements may request a fair hearing. Once a person's request is initiated, the department shall take no adverse action as a result of a person's failure to comply with the treatment at issue pending a decision.

[Statutory Authority: RCW 74.08.090, 93-16-058 (Order 3559), § 388-235-7100, filed 7/29/93, effective 8/29/93.]

WAC 388-235-7200 Other agency referral requirements. (1) The department shall screen each person to determine appropriateness of referral to other agencies which can reasonably be expected to reduce the need for assistance.

(2) For GAU eligibility, an incapacitated person shall accept and follow through on required referrals to other agencies, unless there is good cause for failure to do so as provided under WAC 388-235-7500.

[Statutory Authority: RCW 74.08.090, 93-16-058 (Order 3559), § 388-235-7200, filed 7/29/93, effective 8/29/93.]

WAC 388-235-7300 ADATSA referral requirements.

(1) The department shall refer a person claiming incapacity based primarily on alcoholism or drug dependency for evaluation under the alcoholism and drug addiction treatment and support act (ADATSA).

(2) The department shall evaluate a person for general assistance who appears to have significant mental or physical impairments resulting from, or in addition to, alcoholism or drug addiction when the person:

(a) Indicates upon application that other physical or mental impairments may be incapacitating in themselves; or

(b) The person is rejected for the alcoholism and drug addiction treatment and support program, and/or medical evidence obtained by assessment for that program indicates other significant medical impairments may exist.

(3) Any general assistance applicant or recipient shall be required to undergo an alcohol/drug assessment when the:

(a) Person claims an alcohol or drug problem; or

(b) Department obtains medical or clinical evidence indicating that within the last eighteen months, such a problem appears to exist; or

(c) Department receives information that the person has been arrested for an alcohol- or drug-related offense within the last ninety days; or

(d) Person meets one or more of the criteria in subsections (3)(a) through (c) of this section and the need for a protective payee must be established.

(4) Applicants whose mental, emotional, and/or physical condition is caused or exacerbated by alcoholism or drug addiction must have eligibility for general assistance based solely on the mental, emotional, and/or physical condition.

(a) The effects of the alcoholism or drug addiction must be differentiated from the other condition in order to determine incapacity.

(b) Unless it can be reasonably established that the other condition would remain incapacitating for at least sixty days of abstinence from alcohol or drugs, the person is not eligible for general assistance.

(5) When the effects of alcoholism or drug addiction in the applicant's mental, emotional, and/or physical condition cannot be clearly differentiated, the department shall refer the person to ADATSA for evaluation and/or treatment.

(6) The provisions under subsections (4) and (5) of this section apply to recipients as well, except that a person whose alcohol/drug addiction cannot be clearly differentiated from any physical/mental impairments and eligibility established

under the ADATSA or GAU program will remain on GAU subject to WAC 388-235-8130 provisions.

(7) The department may require a person to undergo a period of alcohol or drug treatment before re-evaluating the person's eligibility for general assistance.

(8) The department shall determine program eligibility for a person impaired by chemical dependency, who also has mental or physical impairments, as follows:

(a) A person qualifying for both general assistance and ADATSA shelter program may choose either program;

(b) A person qualifying for both general assistance and ADATSA treatment shall participate in ADATSA treatment when it can reasonably be expected to enable the person to work or reduce the need for assistance, unless the person has good cause to refuse; or

(c) A person qualifying for general assistance who has good cause to refuse or who does not qualify for ADATSA treatment, shall be required to cooperate with an alternative alcohol or drug treatment plan which can reasonably be expected to enable the person to work or to reduce the need for assistance, unless there is good cause to refuse.

[Statutory Authority: RCW 74.04.057, 94-13-202 (Order 3743), § 388-235-7300, filed 6/22/94, effective 7/23/94. Statutory Authority: RCW 74.08.090, 93-16-058 (Order 3559), § 388-235-7300, filed 7/29/93, effective 8/29/93.]

WAC 388-235-7400 Protective payments. (1) The department shall issue a general assistance grant to a client in the form of protective payment when:

(a) The department determines the client is unable to manage the client's funds; or

(b) A department-designated chemical dependency assessment center diagnoses the client as chemically dependent and determines the client used drugs or alcohol within the ninety-day period immediately preceding assessment.

(2) The department shall have the discretion to waive the protective payment requirement for an actively addicted client when the department determines that the client has the ongoing ability to manage the client's funds.

(3) The department may issue a general assistance grant to the client in the form of vendor payment when no suitable protective payee is available.

[Statutory Authority: RCW 74.04.057, 94-13-202 (Order 3743), § 388-235-7400, filed 6/22/94, effective 7/23/94.]

WAC 388-235-7500 Good cause for refusing medical treatment or other agency referrals. The department shall find that a client has good cause for refusing required medical treatment when such client's refusal is based on any of the following conditions:

(1) The client is genuinely fearful of undergoing required treatment. Such fear may appear to be unrealistic or irrational; however, fear exists in such a degree that treatment would be adversely affected;

(2) The client could lose a faculty, or the remaining use of faculty, and refuses to accept the risk;

(3) Because of the client's definitely stated religious scruples, the client will not accept required medical treatment;

(4) The client is temporarily unable to participate in required medical treatment, due to an intervening incapacity.

The temporary inability to participate must be documented by medical evidence. The requirement to participate is again imposed as soon as the client is able to participate;

(5) The client was not properly notified of the treatment required and/or the consequences for failure to comply with these requirements;

(6) The client's treatment required by previous written notification is subsequently determined by the department to have been inappropriate or unavailable. The department shall consider treatment unavailable when the treatment includes copayments or service charges not covered by the department, and the client is denied access to the treatment due to an inability to pay; or

(7) The client has limitations or impairments consistent with the definition of necessary supplemental accommodation services (NSA) and the effects of those limitations or impairments substantially contributed to the client's refusal to accept treatment or pursue services from other agencies.

[Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090. 97-02-047, § 388-235-7500, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-7500, filed 7/29/93, effective 8/29/93.]

WAC 388-235-7600 Sanction for refusing medical treatment or other agency referrals. The department shall terminate GAU to a person who has been referred to, but refuses to accept a referral to or pursue available required medical treatment or available services or benefits from other agencies without good cause until the person:

(1) Agrees to accept and/or pursue such treatment or service; and

(2) Is subject to the following maximum periods of ineligibility after reapplication:

(a) First refusal - one week;

(b) Second refusal within six months - one month; and

(c) Third and subsequent refusals within one year - two months.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-7600, filed 7/29/93, effective 8/29/93.]

WAC 388-235-8000 Redetermination of financial eligibility. The department shall redetermine financial eligibility for a GAU client every six months or more often of continuous receipt of assistance.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-8000, filed 7/29/93, effective 8/29/93.]

WAC 388-235-8100 Redetermination of incapacity.

(1) The department shall redetermine incapacity for a GAU recipient every twelve months or more often, but may redetermine a recipient's incapacity at any time based on new information.

(2) The department shall redetermine a recipient's eligibility due to incapacity based on current medical information.

(3) If a recipient's incapacity is not substantiated and the conditions in WAC 388-235-8130 are met, then the department shall deny continued eligibility.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-8100, filed 7/29/93, effective 8/29/93.]

(1999 Ed.)

WAC 388-235-8130 Determining a recipient is no longer incapacitated—Termination proviso. (1) The department shall demonstrate one or more of the following conditions exist before determining a recipient is not incapacitated:

(a) Clear improvement in the recipient's overall medical condition based on new medical evidence. "Clear improvement" means, since incapacity was established:

(i) The physical or mental impairment, on which incapacity was based, has decreased in severity to the point where the recipient is capable of gainful employment; or

(ii) The effect of that impairment on work-related activities has been significantly diminished through therapy, medication, or rehabilitation to the point where the recipient is capable of gainful employment; or

(b) A previous error in the eligibility decision. "Previous error" means a client's incapacity was previously established based on:

(i) Faulty or insufficient information; or

(ii) An erroneous procedure based on the rule in effect at the time.

(2) The department shall not apply the clear improvement or previous error criteria under subsection (1) of this section when:

(a) A person has a break in assistance of over thirty days and the person does not meet the criteria for retroactive reinstatement as required under WAC 388-235-8200;

(b) The department determines the recipient is engaged in gainful employment;

(c) The department determines a recipient receiving services through the division of vocation rehabilitation (DVR) is not incapacitated, but assistance has been extended through the completion of the training program by an exception to policy; or

(d) The recipient does not meet the categorical eligibility requirements for the GAU program.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-8130, filed 7/29/93, effective 8/29/93.]

WAC 388-235-8140 Redetermination of eligibility based on mental retardation. The department shall consider a person's incapacity established without medical documentation at the time of review when the person is currently receiving GAU based on mental retardation if the client:

(1) Has submitted current medical evidence documenting a diagnosis of mental retardation with a full scale score on the Wechsler Adult Intelligence Scale (WAIS) of seventy or lower; or

(2) Has submitted current medical evidence documenting a diagnosis of mental retardation or borderline intellectual functioning with a full scale score on the WAIS of seventy-one to seventy-five and meets the following criteria:

(a) Has submitted current medical evidence which documents another mental or physical impairment of marked severity; and

(b) The current medical evidence documents that medical treatment for the other mental or physical impairment is not likely to restore or substantially improve the person's ability to work.

(3) Cooperates with required referral to the division of developmental disabilities (DDD) and an application for SSI.
 [Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-8140, filed 7/29/93, effective 8/29/93.]

WAC 388-235-8150 Redetermination for a recipient appearing to meet federal disability criteria for SSI. The department may extend the incapacity period up to one year from the latest date of incapacity determination, without further medical documentation, when the department determines the client appears to meet federal disability criteria to receive SSI.

(1) At the end of the one-year period, the department shall redetermine the client's GAU eligibility based on current medical evidence.

(2) If the client is denied SSI after application and any administrative appeal before the end of the incapacity certification period, the department shall adjust the client's incapacity period to be the greater of:

(a) The end of the previously established incapacity period based on current medical evidence; or
 (b) Sixty days after the SSI denial date.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-8150, filed 7/29/93, effective 8/29/93.]

WAC 388-235-8200 Reinstating eligibility after termination due to lack of medical evidence. (1) The department shall reinstate a client's eligibility the day following the date of termination if assistance was terminated due to lack or insufficiency of medical evidence to establish incapacity if:

(a) The lack or insufficiency of medical evidence is not due to the client's failure to cooperate in gathering said evidence; and

(b) The client provides the additional medical evidence subsequent to the termination, which establishes that the client has been, and continues to be, incapacitated since the date of termination; and

(c) The additional medical evidence substantiates incapacity.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-8200, filed 7/29/93, effective 8/29/93.]

WAC 388-235-9000 Benefits from other programs. (1) The department shall deny a request for, or terminate, general assistance-unemployable (GAU) to a person:

(a) Eligible for or receiving aid to families with dependent children (AFDC);

(b) Eligible for or whose needs are met by SSI, except as provided under WAC 388-235-9300;

(c) Under sanction for failure to comply with AFDC or supplemental security income (SSI) requirements;

(d) Failing or refusing to cooperate without good cause in obtaining AFDC or SSI;

(e) Unemployable due to alcohol or drug addiction. The department shall refer such person to the alcoholism and drug addiction treatment and support program.

(2) If otherwise eligible, the department shall not deny requests for GAU to a person found ineligible for AFDC, as described under WAC 388-215-1820.

[Title 388 WAC—p. 502]

[Statutory Authority: RCW 74.08.990 and Bordner vs. Rahm #84-2-00435-2. 95-03-048 (Order 3824), § 388-235-9000, filed 1/11/95, effective 2/11/95. Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-9000, filed 7/29/93, effective 8/29/93. Formerly WAC 388-26-145 (part).]

WAC 388-235-9100 GAU pending SSI eligibility. The department shall authorize GAU to a client, who in the department's opinion, may become eligible for or is seeking SSI. Such assistance shall be authorized through the month SSI payments begin if the client:

- (1) Applies for SSI and follows through with the application; and
- (2) Assigns the initial or reinstated SSI payment to DSHS as provided under WAC 388-235-9200; and
- (3) Is otherwise eligible.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-9100, filed 7/29/93, effective 8/29/93.]

WAC 388-235-9200 Assignment and recovery of interim assistance. (1) "Interim assistance" means the state funds the department provides to, or on behalf of, the client to meet basic needs during the:

- (a) Interim period the client's initial application for SSI is pending and subsequently approved; or
- (b) Period the client's SSI payments were suspended or terminated, and subsequently reinstated for that period; and
- (c) The month recurring SSI payments begin.

(2) The department shall require a client, who in the department's opinion may become eligible for or is seeking SSI, to assign the initial or reinstated SSI payment to the department. The assignment shall be up to the amount of the interim assistance the department provides to the client.

(3) The department shall recover interim assistance from the client's initial or reinstated SSI payment when provided totally out of state funds.

(4) The department shall provide up to twenty-five percent of the interim assistance reimbursement on a case to the attorney who has successfully represented that client in the client's effort to receive SSI.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-9200, filed 7/29/93, effective 8/29/93.]

WAC 388-235-9300 GAU to an SSI recipient whose SSI check is lost, stolen, or missent. (1) The department may grant GAU to an SSI client whose SSI check has been lost, stolen, missent, or otherwise delayed when the client:

(a) Agrees, in writing, to repay the amount of the GAU issued; and

(b) Meets all other GAU eligibility requirements.

(2) When the client's SSI check is lost in the mail, the department shall:

(a) Delay the issuance of GAU for ten working days from the first of the month in which the SSI check was issued; or

(b) Waive the delay and issue the check immediately if the department determines the SSI client has an emergent need.

[Statutory Authority: RCW 74.08.090. 93-16-058 (Order 3559), § 388-235-9300, filed 7/29/93, effective 8/29/93.]

Chapter 388-240 WAC
ALCOHOL/DRUG PROGRAMS

WAC

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WAC 388-240-0010 Introduction. This chapter contains the rules for program service levels and for determining client eligibility for:

- (1) The alcohol/drug detoxification program; and
- (2) The Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) program. The ADATSA program is divided into two subprograms:

- (a) Treatment; and
- (b) Shelter.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-0010, filed 9/8/93, effective 10/9/93.]

WAC 388-240-0020 Definitions. (1) "Active addiction" means use of alcohol or drugs by a diagnosed alcoholic or drug addict within a specific time period immediately preceding the latest assessment center evaluation:

- (a) For ADATSA shelter eligibility purposes, within the sixty-day period immediately preceding assessment.
- (b) For ADATSA treatment eligibility purposes, within the ninety-day period immediately preceding assessment.

(2) "Alcohol and Drug Addiction Treatment and Support Act (ADATSA)" is a legislative enactment providing state-financed treatment and support to indigent alcoholics and drug addicts.

(3) "Gainfully employed" means performing in a regular and predictable manner an activity for pay or profit. Gainful employment does not include noncompetitive jobs such as work in a department-approved sheltered workshop or sporadic or part-time work, if the person, due to functional limitation, is unable to compete with unimpaired workers in the same job.

(4) "Intensive protective payee" provides case management services for an ADATSA shelter client. These services include:

- (a) Sufficient controls of monthly shelter expenditures as necessary to ensure the client's basic needs are met; and
- (b) Preventing the diversion of assistance toward purchase of alcohol or drugs.

(5) "Protective payee" means a person or agency who has the authority and responsibility to make decisions about

the expenditure of outpatient treatment living stipends for an outpatient client.

(6) "Shelter services" or "shelter assistance" means:

(a) Room and board in a supervised living arrangement to an ADATSA client by a facility under contract with the department; or

(b) Where contracted facilities are not available, benefits paid to an intensive protective payee for an ADATSA client living in independent housing.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-0020, filed 9/8/93, effective 10/9/93.]

WAC 388-240-1100 Detoxification services. The department shall only pay for three-day detoxification services for acute alcoholic condition or five-day detoxification services for acute drug addiction for eligible persons when the services are:

(1) Directly related to detoxification; and

(2) Performed by a certified detoxification center or a general hospital contracted with the department to perform these services.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-1100, filed 9/8/93, effective 10/9/93.]

WAC 388-240-1200 Detoxification eligibility. (1) The department shall consider a person eligible who is an AFDC/general assistance, a medical assistance program, or a supplemental security income (SSI) beneficiary; or

(2) The department shall consider a person eligible who does not have combined nonexempt income and/or resources that exceed the aid to families with dependent children (AFDC) payment standards. The department shall:

(a) Exempt the following resources for the alcoholism and drug detoxification program:

(i) A home;

(ii) Household furnishings and personal clothing essential for daily living;

(iii) Other personal property used to reduce need for assistance or for rehabilitation; and

(iv) A used and useful automobile.

(b) Not exempt the following resources:

(i) Cash;

(ii) Marketable securities; and

(iii) Any other resource not specifically exempted that can be converted to cash.

(c) Deduct or exempt the following from income:

(i) Mandatory expenses of employment;

(ii) Total income and resources of a noninstitutionalized SSI beneficiary;

(iii) Support payments paid under a court order; and

(iv) Payments to a wage earner plan specified by a court in bankruptcy proceedings, or previously contracted major household repairs when failure to make such payments will result in garnishment of wages or loss of employment.

(3) The department shall not require the person receiving detoxification services to incur a deductible as a factor of eligibility for the covered period of detoxification.

(4) The department shall determine eligibility for the detoxification program on the basis of information shown on the department's application forms.

(5) The department shall require supplemental forms, verification procedures, and/or face-to-face interviews only in cases where there is a specific reason for requiring further verification of eligibility.

(6) When the department is notified within ten working days of the date detoxification began, the department shall cover this period if all eligibility factors are met.

(7) The department shall continue the effective period of eligibility from the date detoxification treatment began through the end of the month in which the client completed the three-day or five-day treatment.

[Statutory Authority: RCW 74.08.090, 93-19-039 (Order 3632), § 388-240-1200, filed 9/8/93, effective 10/9/93.]

WAC 388-240-2100 ADATSA purposes and programs. (1) The purpose of ADATSA is to:

(a) Assist in the rehabilitation of alcoholics and drug addicts who can benefit from treatment; or

(b) Provide a program of shelter services for those alcoholics and drug addicts whose chemical dependency has resulted in incapacitating physiological or cognitive impairments.

(2) The department shall provide eligible persons with those ADATSA services available within legislative appropriation and only to the extent such service conforms to all conditions and limitations set by the department.

(3) Persons qualifying for the ADATSA program may be eligible for:

(a) Alcohol/drug treatment services and support described under WAC 388-240-4100 and 388-240-4400; or

(b) Shelter services as described under WAC 388-240-5100.

(4) A person eligible for ADATSA shall be eligible for medical care services as described under WAC 388-86-120 or its successor.

[Statutory Authority: RCW 74.08.090, 93-19-039 (Order 3632), § 388-240-2100, filed 9/8/93, effective 10/9/93.]

WAC 388-240-2300 ADATSA categorical eligibility.

(1) A person eligible for ADATSA services shall:

(a) Be eighteen years of age or older;

(b) Be a resident of Washington as defined by the GAU program; and

(c) Be either a United States citizen or alien who:

(i) Is lawfully admitted for permanent residence;

(ii) Is otherwise permanently residing in the United States under color of law; or

(iii) Has been granted temporary residency status under the Immigration Reform and Control Act.

(d) Provide the department with the applicant's Social Security number. If the applicant cannot finish a Social Security number because it has not been issued or is not known, the applicant shall apply for a number before authorization of assistance. The applicant shall provide the Social Security number to the department upon receipt.

(e) Meet the same income and resource criteria as required by the general assistance-unemployable (GA-U) program; except, persons excluded from GA-U under WAC 388-235-9000, because they are clients of federal aid, may be eligible for ADATSA treatment services.

(2) A person placed in an alcohol or drug congregate care facility shall meet the payment and procedural requirements set forth in WAC 388-15-568 or its successor. However, the department shall not require a client receiving services in an intensive inpatient chemical dependency treatment program of thirty days or less to participate in the cost of care.

(3) The department shall require a client with income while residing in a recovery house, extended care recovery house, or long-term care or drug residential treatment facility to contribute toward the cost of care of that portion of their income in excess of the clothing and personal incidental standard. This participation shall:

(a) Begin the month following the month of admission; and

(b) For benefits, be computed by the department according to applicable rules for the program under which the benefits are received.

[Statutory Authority: RCW 74.08.090, 93-19-039 (Order 3632), § 388-240-2300, filed 9/8/93, effective 10/9/93.]

WAC 388-240-2400 ADATSA treatment—Eligibility requirements. (1) Within the current appropriation, the department may grant ADATSA treatment services to an alcoholic or drug addict.

(2) An eligible person for ADATSA treatment services shall meet the:

(a) Financial eligibility criteria in WAC 388-240-2300; and

(b) Incapacity eligibility criteria in WAC 388-240-2450.

[Statutory Authority: RCW 74.08.090, 93-19-039 (Order 3632), § 388-240-2400, filed 9/8/93, effective 10/9/93.]

WAC 388-240-2450 ADATSA treatment—Incapacity requirements. (1) In order to qualify for ADATSA treatment services, a person shall be:

(a) Diagnosed as having a mild, moderate, or severe dependency on a psychoactive substance class other than nicotine, using the criteria for *Psychoactive Substance Dependence in the Diagnostic and Statistical Manual of Mental Disorders* (third edition revised), published by the American Psychiatric Association (this publication will be referred to below as the DSM III-R.); and

(b) Incapacitated, i.e., unable to work. Incapacity shall exist if the applicant meets one or more of the following:

(i) Currently pregnant or up to two months post partum; or

(ii) Diagnosed as at least moderately psychoactive substance dependent and referred for treatment by child protective services; or

(iii) Diagnosed as severely psychoactive substance dependent and currently an intravenous drug user; or

(iv) Diagnosed as severely psychoactive substance dependent and has:

(A) One prior diagnosis of severe psychoactive substance dependency by an assessment center; or

(B) At least one prior admission to a department-approved alcohol/drug treatment or detoxification program.

(v) Diagnosed as severely psychoactive substance dependent and has had two or more arrests for offenses directly related to the chemical dependency; or

(vii) Lost two or more jobs during the last six months as a direct result of chemical dependency; or

(viii) Admitted to a department-approved outpatient treatment program during the last six months and the outpatient treatment provider certifies the treatment recipient is not benefiting from outpatient treatment and needs more intensive chemical dependency treatment services.

(c) Not eligible for ADATSA treatment, notwithstanding subsection (b) of this section, when the person:

(i) Is not clearly diagnosed as currently dependent on psychoactive substances other than nicotine; or

(ii) Has abstained from alcohol and drug use for the last ninety days, excluding days spent while incarcerated; or

(iii) Has been gainfully employed in a job in the competitive labor market at any time during the last thirty days.

(2) A person who is successfully participating in ADATSA outpatient treatment services shall be considered incapacitated through completion of the planned treatment, even if the person:

(a) Becomes employed;

(b) Abstains from alcohol or drug use; or

(c) Has full or partial remission of psychoactive substance abuse dependence.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-2450, filed 9/8/93, effective 10/9/93.]

WAC 388-240-2500 ADATSA shelter—Eligibility requirements. (1) Within the current appropriation, the department may grant ADATSA shelter services to an alcoholic or drug addict.

(2) An eligible person for these ADATSA shelter services shall meet the:

(a) Financial eligibility criteria in WAC 388-240-2300; and

(b) Incapacity eligibility criteria in WAC 388-240-2550.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-2500, filed 9/8/93, effective 10/9/93.]

WAC 388-240-2550 ADATSA shelter—Incapacity requirements. To meet shelter incapacity standards, a person shall meet the following conditions:

(1) Be actively addicted, meaning having used alcohol or drugs within the sixty-day period immediately preceding the latest assessment center evaluation, as determined by the assessment center;

(2) Have resulting physiological or organic damage, or have resulting cognitive impairment not expected to dissipate with sixty days of sobriety or detoxification;

(3) To qualify on the basis of physical impairment, the physiological or organic damage must have a severity rating of "03" or more as defined under the GA-U program;

(4) To qualify on the basis of cognitive impairment, the applicant must have:

(a) At least a moderate impairment of ability to understand, remember, and follow complex instructions; and

(b) An overall moderate impairment in ability to:

(i) Learn new tasks;

(ii) Exercise judgment;

(iii) Make decisions, and

(iv) Perform routine tasks without undue supervision.

(5) The department shall require the impairments described in subsections (2), (3) and (4) of this section to be supported by documented, objective, and current medical evidence provided by a licensed physician, licensed clinical psychologist, or mental health professional as defined by RCW 71.05.020.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-2550, filed 9/8/93, effective 10/9/93.]

WAC 388-240-2570 ADATSA shelter—Eligibility determination and review. The department shall:

(1) Make an eligibility decision for ADATSA shelter within forty-five days of the date of application, except in circumstances beyond the control of the agency such as failure or delay in securing necessary information or documentation on the part of the applicant;

(2) Redetermine incapacity and financial and medical eligibility for ADATSA shelter every six months or more often; and

(3) Provide adequate and advance notice of adverse action.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-2570, filed 9/8/93, effective 10/9/93.]

WAC 388-240-2600 ADATSA SSI referral requirements. (1) An ADATSA client the department determines potentially eligible for supplemental security income (SSI) shall:

(a) Make application for SSI; and

(b) Assign the initial SSI payment to the department of social and health services up to the amount of ADATSA assistance provided to the recipient pending approval of the SSI application.

(2) To establish eligibility, the department shall assist an ADATSA client in:

(a) Making application for SSI; and

(b) Obtaining the necessary documentation required by the Social Security Administration.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-2600, filed 9/8/93, effective 10/9/93.]

WAC 388-240-3100 ADATSA assessment center—Role. (1) A department-designated chemical dependency assessment center shall determine incapacity based on alcoholism or drug addiction. The assessment center is the department's sole source of medical evidence required for the diagnosis and evaluation of alcoholism/drug addiction and its effects on employability.

(2) The department shall:

(a) Require a current assessment, in writing, for all ADATSA clients; and

(b) Pay the costs of assessments needed to determine eligibility.

(3) ADATSA assessment centers shall:

(a) Be responsible for diagnostic evaluation and treatment placement;

(b) Not be responsible for providing direct treatment;

(c) In accordance with chapter 275-19 WAC or its successor, conduct a face-to-face diagnostic assessment to determine if the client:

(i) Is chemically dependent;
 (ii) Meets incapacity standards for treatment under WAC 388-240-2400; and
 (iii) If incapacitated, is willing, able, and eligible to undergo a course of ADATSA treatment.

(4) The assessment center shall determine a course of treatment based on an individual assessment of alcohol/drug involvement and treatment needs in accordance with RCW 70.96A.100 and the procedures under chapter 275-19 WAC or its successor.

(5) Once the treatment client's financial and medical eligibility is established, the assessment center shall:

(a) Develop an ADATSA treatment plan;

(b) Arrange all placements into ADATSA treatment taking into account the treatment priorities described under WAC 388-240-4200;

(c) Provide the client with written notification of the client's right to return to the community service office (CSO) at any time while receiving ADATSA treatment. This includes, but is not limited to, those situations where the client is discharged from any residential or outpatient agency providing services under contract to the department;

(d) Provide the client with written notification of the client's right to request a fair hearing to challenge any action affecting eligibility for ADATSA treatment;

(e) Provide ongoing case monitoring of treatment services; and

(f) Notify the community services office promptly of all placement or eligibility status changes.

(6) When evaluating the person's ability to benefit from primary outpatient treatment, the assessment center shall consider clinical or medical factors indicating the likelihood of a client's success in a less-structured primary treatment modality. Such factors may include:

(a) An assessment of former treatment history;
 (b) The number of detoxification admissions;
 (c) The chronicity and degree of incapacity of the client; and
 (d) Social factors, such as:
 (i) The availability of social support systems;
 (ii) Family support; and
 (iii) Stable living arrangement.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-3100, filed 9/8/93, effective 10/9/93.]

WAC 388-240-4100 ADATSA treatment limitations.

(1) The department shall offer ADATSA treatment services to an eligible person incapacitated by alcoholism or drug addiction, subject to:

(a) Availability defined under WAC 388-240-2100; and
 (b) Priority classifications set forth under WAC 388-240-4200.

(2) The department shall limit a person's treatment services to a maximum of six months in a twenty-four-month period. The twenty-four-month period begins on the date of initial entry into treatment.

(3) The department shall limit residential treatment to the following durations:

(a) Intensive inpatient treatment, not to exceed thirty days per admission;

(b) Recovery house treatment, not to exceed sixty days per admission;

(c) Extended care recovery house treatment, not to exceed ninety days;

(d) Long-term care residential treatment, not to exceed one hundred eighty days;

(e) Drug residential treatment, not to exceed one hundred eighty days.

(4) An ADATSA client shall not receive more than ninety days of ADATSA outpatient treatment in a twenty-four-month period, if referred:

(a) Directly to outpatient treatment; or

(b) Following a residential placement.

(5) The department shall only offer medical services to a person eligible for ADATSA treatment choosing methadone chemical dependency treatment, as referenced under WAC 388-86-120 or its successor.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-4100, filed 9/8/93, effective 10/9/93.]

WAC 388-240-4200 ADATSA treatment terminations and reinstatements.

(1) The department shall terminate an ADATSA client who withdraws or is discharged from treatment for any reason. The client must reapply and be re-referred to the assessment center if the client requires further ADATSA treatment services.

(a) The department shall refer an ADATSA client demonstrating an inability to remain abstinent in outpatient treatment to residential treatment.

(b) The department may require a client dropping out of treatment in the intensive inpatient modality to repeat this phase.

(c) The department may require a client dropping out of treatment during the recovery house or outpatient modality to:

(i) Return to the modality from which the client dropped out; or

(ii) Enter intensive inpatient treatment if, in the clinical judgment of the assessment center, a more structured form of treatment seems warranted.

(2) A client absent from inpatient treatment or other residential services for less than seventy-two hours may reenter that program without being considered as having dropped out. This is done at the discretion of the treatment service administrator and without requiring the client to apply for readmittance through the assessment center.

(3) An ADATSA client terminating treatment shall not be eligible for benefits beyond the month in which treatment services end. Regulations regarding advance and adequate notice still apply, but an ADATSA treatment client shall not be eligible for continued assistance pending a fair hearing as provided under WAC 388-33-377 or its successor.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-4200, filed 9/8/93, effective 10/9/93.]

WAC 388-240-4400 ADATSA treatment priority groups.

(1) When assigning residential admissions, the assessment center shall:

(a) Give first priority to a pregnant woman or a parent with a child in the home;

(b) Additionally, provide priority access to ensure admission for:

- (i) A person referred through by the department's children's protective services (CPS) program; and
- (ii) An injecting drug user (IDU).

(2) When assigning outpatient admissions, the assessment center shall:

(a) Give first priority to a pregnant woman or a parent with a child in the home unable to access Title XIX outpatient treatment;

(b) Additionally, provide priority access to ensure admission for:

- (i) A person completing residential treatment;
- (ii) A person referred through CPS; and
- (iii) An IDU.

(3) The department may deny ADATSA treatment services to a person able to access, at no cost to the person, comparable state-approved chemical dependency treatment.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-4400, filed 9/8/93, effective 10/9/93.]

WAC 388-240-4600 ADATSA treatment living allowance. (1) An ADATSA client in residential treatment shall be eligible for an allowance based on the department's current payment standard for clothing and personal incidentals.

(2) An ADATSA client in an outpatient treatment modality shall be eligible for a treatment living allowance for housing and other living expenses.

(3) The department shall:

- (a) Base the living allowance amount on the current ADATSA payment standard;
- (b) Issue this living allowance directly to the outpatient provider as (protective) payee; and
- (c) Not authorize the use of any treatment living allowance to pay for shelter in a dormitory setting not requiring sobriety as a condition of residence.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-4600, filed 9/8/93, effective 10/9/93.]

WAC 388-240-5100 ADATSA shelter services. (1) The department shall limit ADATSA shelter services to shelter assistance in the contracted facilities unless the client resides in a county described under subsection (2) of this section.

(2) A client residing in a county where a contracted shelter bed is not available may receive shelter assistance in independent housing, subject to the following provisions:

(a) The client shall, as a condition of continued eligibility, move to a contracted shelter bed when available. "Availability" means the existence of a vacant shelter bed, rather than whether or not a particular A/R is accepted or rejected from a shelter facility based on disciplinary problems;

(b) The client shall receive the monthly shelter assistance payment through an intensive protective payee defined under WAC 388-240-6100; and

(c) The department shall only provide assistance for independent housing to a client residing in a permanent residential structure. The client must have a deed of purchase, rental agreement, or other verifiable written agreement

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between the client and the person or entity to whom the client is obligated for shelter costs or from whom the recipient is receiving supplied shelter.

(3) The department shall base the amount of a client's assistance for independent housing and basic needs on the appropriate payment standard for the GA-U program. For a client in a contracted shelter facility, the department shall provide an allowance for clothing and personal incidentals based on the standard for congregate care facilities.

(4) The department shall terminate a client receiving contracted shelter services:

(a) When the client is discharged from the facility for disciplinary reasons; or

(b) If the client subsequently leaves shelter, without notice, for more than seventy-two hours.

(5) The department shall continue benefits for an ADATSA shelter requesting a fair hearing within the advance notice period before termination is to occur as required under WAC 388-37-377 or its successor.

[Statutory Authority: RCW 74.08.090. 93-19-039 (Order 3632), § 388-240-5100, filed 9/8/93, effective 10/9/93.]

WAC 388-240-6100 ADATSA protective payees. (1) The department shall pay the assistance needs of an ADATSA client receiving outpatient treatment or shelter assistance by protective payee or vendor payment. The protective payee for:

(a) An outpatient client shall be the same agency providing outpatient treatment;

(b) A shelter client in independent housing shall be an agency under contract with the department to provide intensive protective payee services described under subsection (5) of this section; and

(c) A shelter client residing in a contracted shelter facility shall be the facility operator. The facility operator shall have the authority to use personal discretion on the method of disbursing the client's clothing and personal incidental money each month.

(2) The protective payee for an outpatient client shall:

(a) Have the authority and responsibility to make decisions about the expenditure of outpatient treatment stipends;

(b) Encourage the client to participate in the decision-making process. The amount of decision-making the protective payee allows the client shall depend upon the level of responsibility the client demonstrates; and

(c) Disburse funds to meet the basic needs of a client's shelter, utilities, food, clothing, and personal incidentals.

(3) The outpatient protective payee may use discretion on the method of disbursing to the client any cash balance remaining from the client's monthly assistance warrant. The protective payee has the authority to apportion any remaining funds to the client at regular intervals throughout the month.

(4) The intensive protective payee shall provide to a client case management services to include, but not be limited to:

(a) Disbursement of a payment for shelter and utilities, such as a check directly to the landlord, mortgage company, utility company, etc;

(b) Direct payment to vendors directly for goods or services provided to or for the recipient, including personal and incidental expenses; and

(c) An exception only where unusual circumstances prevent direct payment and the recipient is unlikely to divert the money to purchasing alcohol or drugs.

(5) A shelter client in independent housing has the right to request a change of an intensive protective payee within the county if dissatisfied with the department's selection of a particular intensive protective payee. If the department determines good cause exists for the payee change, the department shall reassign the client to another intensive protective payee, if available.

(6) In the event the client or protective payee relationship is terminated for any reason, the protective payee shall return any remaining funds to the department.

[Statutory Authority: RCW 74.08.090, 93-19-039 (Order 3632), § 388-240-6100, filed 9/8/93, effective 10/9/93.]

Chapter 388-255 WAC SPECIAL PAYMENTS

WAC

388-255-1020	Additional requirements—General provisions.
388-255-1050	Additional requirements—Restaurant meals.
388-255-1100	Additional requirements—Home-delivered meals (meals on wheels).
388-255-1150	Additional requirements—Food for guide dog or service animal.
388-255-1200	Additional requirement—Telephone.
388-255-1250	Additional requirements—Laundry.
388-255-1300	Additional requirements—Winterizing homes AFDC.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-255-1350	Additional requirements for emergent situations. [Statutory Authority: RCW 74.08.090, 94-09-001 (Order 3729), § 388-255-1350, filed 4/6/94, effective 5/7/94.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-255-1400	One-time grant—Authorization—Disbursement. [Statutory Authority: RCW 74.08.090, 94-09-001 (Order 3729), § 388-255-1400, filed 4/6/94, effective 5/7/94. Formerly WAC 388-33-595.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-255-1020 Additional requirements—General provisions. (1) The department shall provide additional requirements under the circumstances and limitations specified in this chapter.

(2) The department shall provide for certain additional requirements when a person's circumstances indicate that the item is essential in according to the department established criteria. In determining whether the need for an additional requirement exists, the department shall consider:

- (a) The circumstances that created the need;
- (b) The person's health or living conditions; and
- (c) Other pertinent factors as described under subsection (4) of this section.

(3) The department shall verify the need for an additional requirement.

(4) The need for an additional requirement may regularly recur or be nonrecurring. When the requirement is ongoing, the department shall:

(a) Add the requirement to the basic monthly grant payment for the assistance unit;

(b) Establish a plan for periodically reviewing the need for the requirement;

(c) Reestablish the need for an ongoing additional requirement as often as the case plan indicates, but at least:

(i) Semiannually for AFDC, or refugee assistance recipients; or

(ii) Annually for general assistance or SSI recipients, when the need is not likely to change; or

(iii) More frequently if circumstances are likely to change.

[Statutory Authority: RCW 74.08.090, 94-09-001 (Order 3729), § 388-255-1020, filed 4/6/94, effective 5/7/94.]

WAC 388-255-1050 Additional requirements—Restaurant meals.

(1) The department may authorize additional requirements for restaurant meals for clients eligible for AFDC, refugee or general assistance grants, and SSI recipients.

(2) The department shall authorize restaurant meals as an additional requirement when the department determines:

(a) A client is physically or mentally unable to prepare meals; and

(b) Board, or board and room, is not available or the use of such facilities is not feasible for the person.

(3) The monthly standard for restaurant meals is described under WAC 388-250-1750(1).

[Statutory Authority: RCW 74.08.090, 94-09-001 (Order 3729), § 388-255-1050, filed 4/6/94, effective 5/7/94.]

WAC 388-255-1100 Additional requirements—Home-delivered meals (meals on wheels).

(1) The department may authorize additional requirements for home-delivered meals (meals on wheels) for clients eligible for AFDC grants, refugee cash assistance, general assistance grants, or SSI benefits.

(2) The department shall authorize home-delivered meals (meals on wheels) as an additional requirement when the department determines:

(a) A person cannot be expected to prepare all of their own meals, and home-delivered meals are available; and

(b) The person requires help in preparation of meals and would benefit nutritionally or otherwise from home-delivered meals; and

(c) Help in preparation of meals is not reasonably available without cost to the person; and

(d) Board (or board and room) is not available, is not feasible, or is costlier for the recipient.

(4) The department shall determine the monthly standard to be the amount charged by the agency delivering the service. (See WAC 388-250-1750.)

[Statutory Authority: RCW 74.08.090, 94-09-001 (Order 3729), § 388-255-1100, filed 4/6/94, effective 5/7/94.]

WAC 388-255-1150 Additional requirements—Food for guide dog or service animal.

(1) The department may authorize additional requirements for food for a guide dog or service animal for clients eligible for AFDC grants, refugee cash assistance, general assistance grants, or SSI benefits.

(2) The department shall determine the cost of food for a guide dog or service animal to be an additional requirement when the animal has been trained at a recognized school or training facility.

(3) The monthly standard for food for a guide dog or service animal is described under WAC 388-250-1750.

[Statutory Authority: RCW 74.08.090. 94-09-001 (Order 3729), § 388-255-1150, filed 4/6/94, effective 5/7/94.]

WAC 388-255-1200 Additional requirement—Telephone. (1) The department may authorize additional requirements for telephone assistance for clients eligible for AFDC grants, refugee cash assistance, general assistance grants, or SSI benefits.

(2) The department shall authorize telephone services as an additional requirement when the department determines:

(a) The lack of a telephone would endanger the clients life or make a more expensive type of care necessary;

(b) The function of a telephone cannot be performed by other means, including the help of neighbors, relatives or other community services; and

(c) The client has requested participation through their local telephone company in the Washington Telephone Assistance Program.

(3) The monthly standard for telephone is described under WAC 388-250-1750.

[Statutory Authority: RCW 74.08.090. 96-01-017 (Order 3935), § 388-255-1200, filed 12/8/95, effective 1/8/96; 94-09-001 (Order 3729), § 388-255-1200, filed 4/6/94, effective 5/7/94.]

WAC 388-255-1250 Additional requirements—Laundry. (1) The department may authorize additional requirements for laundry for clients eligible for AFDC grants, refugee cash assistance, general assistance grants or SSI benefits.

(2) The department shall authorize laundry as an additional requirement when the department determines:

(a) The client is physically unable to do laundry; and

(b) A person is not able to perform this service for the client at no cost.

(3) The monthly standard for laundry is described under WAC 388-250-1750.

[Statutory Authority: RCW 74.08.090. 94-09-001 (Order 3729), § 388-255-1250, filed 4/6/94, effective 5/7/94.]

WAC 388-255-1300 Additional requirements—Winterizing homes AFDC. (1) The department may authorize additional requirements for winterizing homes for clients eligible for AFDC grants assistance.

(2) The department shall authorize repairs to a home owned or being purchased by an AFDC client as an additional requirement under the following circumstances:

(a) The primary purpose of the repairs is to minimize heat loss or otherwise increase the efficiency of the home heating system;

(b) The repairs are necessary to render the home habitable;

(c) Lack of repairs would require the assistance unit to move to rental quarters;

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(d) The rental costs expended by the assistance unit over a period of two years would exceed the costs, including repairs, attributable to continued occupancy; and

(e) Expenditures for home repair has not been previously made under the policies outlined under subsection (2)(a), (b), (c) and (d) of this section.

(3) The department shall ensure all expenditures for repairs are paid by vendor payments when there is sufficient recorded evidence that a home repair was performed.

(4) The maximum allowance for winterizing a home is described under WAC 388-250-1750.

[Statutory Authority: RCW 74.08.090. 94-09-001 (Order 3729), § 388-255-1300, filed 4/6/94, effective 5/7/94.]

Chapter 388-265 WAC PAYMENT OF GRANTS

WAC

388-265-1150	Protective payee—General information.
388-265-1155	Protective payee selection.
388-265-1200	Emergency and temporary protective payees (TANF/SFA).
388-265-1250	Protective payee or vendor payment due to mismanagement of money.
388-265-1275	Assigning TANF/SFA or GA pregnant or parenting minors to protective payee.
388-265-1300	Assigning TANF/SFA clients sanctioned for noncooperation or nonparticipation with WorkFirst activities to protective payees.
388-265-1375	Transfer from protective payees to guardianship.
388-265-1450	Protective payee responsibility and fees.
388-265-1500	Protective payee plans.
388-265-1600	Ending protective payee status and changing payees.
388-265-1650	Protective payment—Fair hearing rights.
388-265-1750	Protective payee fees.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-265-1010

Grant payment—General provisions. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1010, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-015, 388-33-020, 388-33-025, 388-33-050, 388-33-051 and 388-33-055.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-265-1050

Grant authorization. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1050, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-080, 388-33-085 and 388-33-095.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-265-1100

Grant payee. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1100, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-400 and 388-33-455.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-265-1350

Protective payment—AFDC clients sanctioned for failure or refusal to cooperate with the office of support enforcement. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1350, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-453 (part).] Repealed by 97-08-033 and 97-10-042, filed 3/27/97 and 4/30/97, effective 8/1/97. Statutory Authority: RCW 74.04.050, 74.04.055 and Public Law 104-193, Section 103 (a)(1) (1996).

388-265-1400

Vendor payee. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1400, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-440 and 388-33-460.] Repealed by 98-24-051, filed 1/1/25/98, effective 12/26/98. Statutory Authority: RCW 74.08.090.

388-265-1550

Client notification of protective payee or vendor payee. [Statutory Authority: RCW 74.08.090. 94-10-065]

388-265-1700	(Order 3732), § 388-265-1550, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-444, 388-33-446 and 388-33-457.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-265-1800	Confidential information—Protective payee or vendor payee. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-265-1700, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-449.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-265-1850	Warrant endorsement. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-265-1800, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-525.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-265-1900	Warrant delivery. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-265-1850, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-535, 388-33-545 and 388-33-550.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-265-1950	Warrant cancellation. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-265-1900, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-585.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-265-2000	Loss, theft, or destruction of a client's warrant. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-265-1950, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-576.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-265-1150 Protective payee—General information.

(1) A protective payee is a person or agency who manages client cash benefits to provide for basic needs - housing, utilities, clothing, child care and food. They may also provide services such as training clients in money management.

(2) Clients are assigned to protective payees for the following reasons:

- (a) Emergency or temporary situations where a child is left without a caretaker (TANF/SFA);
- (b) Noncooperation with WorkFirst program requirements (TANF/SFA); or
- (c) Mismanagement of money (TANF/SFA or GA).

[Statutory Authority: RCW 74.08.090, 98-24-051, § 388-265-1150, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1150, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-440 and 388-33-455.]

WAC 388-265-1155 Protective payee selection. (1) Clients may ask for a particular protective payee, but the department makes the final choice.

(2) Protective payees must contract with the department, except for employees of the department who are assigned this function as part of their job duties.

(3) A departmental employee acting as protective payee cannot:

- (a) Have the client in their caseload,

(b) Have the client in the caseloads of other employees under their supervision,

(c) Be responsible for determining or issuing benefits for the client,

(d) Be the office administrator,

(e) Be a special investigator.

(4) For TANF/SFA, a department employee cannot act as protective payee when the department has legal custody or responsibility for placement and care of the child.

[Statutory Authority: RCW 74.08.090, 98-24-051, § 388-265-1155, filed 11/25/98, effective 12/26/98.]

WAC 388-265-1200 Emergency and temporary protective payees (TANF/SFA). An emergency protective payee is assigned when a caretaker relative is not available to take care of and supervise a child due to an emergency.

[Statutory Authority: RCW 74.08.090, 98-24-051, § 388-265-1200, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1200, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-420 (part).]

WAC 388-265-1250 Protective payee or vendor payment due to mismanagement of money. (1) The decision to assign a person to a protective payee because of mismanagement of funds must be based in law, such as teen parents (RCW 74.04.0052) or on documented evidence in the case file. The documentation must be current and show that the mismanagement threatens the well being of a child on TANF/SFA or of the client. Examples of evidence are:

(a) Department employees or others observe the client or client's children are hungry, ill, or not adequately clothed.

(b) Repeated requests for more money, for example emergency additional requirements, or for basic essentials such as food, utilities, clothing, and housing.

(c) A series of evictions or utility shut offs.

(d) Medical or psychological evaluations.

(e) An ADATSA alcohol/drug assessment which establishes incapacity due to alcoholism or drug addiction.

(f) Nonpayment of an in home child care provider when payment has been issued by the department for that purpose.

(g) Complaints from vendors showing a pattern of failure to pay bills or rent.

(2) A lack of money or a temporary shortage of money because of an emergency does not constitute mismanagement.

(3) When a client has a history of mismanaging money, benefits can be paid directly to vendors or through a protective payee.

[Statutory Authority: RCW 74.08.090, 98-24-051, § 388-265-1250, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.04.050, 43.20A.550 and 74.08.090, 97-02-047, § 388-265-1250, filed 12/30/96, effective 1/30/97. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-265-1250, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-420, 388-33-430, 388-33-440 and 388-33-455.]

WAC 388-265-1275 Assigning TANF/SFA or GA pregnant or parenting minors to protective payee. Clients are assigned to protective payees if the clients are:

(1) Under age 18; and

(2) Unmarried; and

(3) Pregnant or have a dependent child.

[Statutory Authority: RCW 74.08.090, 98-24-051, § 388-265-1275, filed 11/25/98, effective 12/26/98. Statutory Authority: RCW 74.08.090 and 74.04.057, 97-20-128, § 388-265-1275, filed 10/1/97, effective 11/1/97. Statutory Authority: Chapter 74.12 RCW and E2 SHB 2798, 94-20-040 (Order 3785), § 388-265-1275, filed 9/28/94, effective 10/29/94.]

WAC 388-265-1300 Assigning TANF/SFA clients sanctioned for noncooperation or nonparticipation with WorkFirst activities to protective payees. (1) Clients in their second month of sanction for noncooperation or non-participation in WorkFirst work activities must be assigned to protective payees.

(2) Clients under sanction remain in protective payee status until they cooperate with WorkFirst and the sanction is removed, as long as they are receiving assistance.

[Statutory Authority: RCW 74.08.090, 98-24-051, § 388-265-1300, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1300, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-450 (part).]

WAC 388-265-1375 Transfer from protective payees to guardianship. (1) In emergency cases where a person is physically or mentally unable to manage their own funds, the client is referred to other divisions of the department for full care, including guardianship.

(2) In cases where a child is eligible for TANF/SFA and the caretaker relative does not use the benefits for adequate care of the child, the case can be referred to the attorney general to establish a limited guardianship.

(3) This process is used only if it appears there is a need for services to go beyond two years.

(4) These guardianships are limited to management of DSHS benefits.

(5) The protective payee plan is changed if a guardian is appointed. The guardian is designated as the payee.

[Statutory Authority: RCW 74.08.090, 98-24-051, § 388-265-1375, filed 11/25/98, effective 12/26/98.]

WAC 388-265-1450 Protective payee responsibility and fees. (1) The protective payee's responsibilities are to:

(a) Manage client funds to pay bills for basic needs, such as housing and utilities, and as directed in the protective payee plans;

(b) Provide money management for client when this item is included in the protective payee plans;

(c) Urge clients to comply with WorkFirst and other program requirements, such as getting a job or attending school;

(d) Provide reports to the department on client progress.

(2) Protective payee vendors are paid up to forty dollars administrative fees per assigned client per month.

[Statutory Authority: RCW 74.08.090, 98-24-051, § 388-265-1450, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1450, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-455 (part).]

WAC 388-265-1500 Protective payee plans. (1) A protective payee plan is developed for each case assigned to a protective payee.

(2) A copy of the plan is provided to:

(a) The protective payee; and

(b) The client.

(3) Protective payee status must be reviewed:

(a) After an initial three month period; and

(b) At least every six months beyond the initial period for on-going cases.

(4) Reviews include evaluation of:

(a) The need for the client to continue in protective payee status;

(b) The need to change the plan;

(c) The client's potential to assume control of their funds (or be removed from protective payee status); and

(d) Protective payee performance.

[Statutory Authority: RCW 74.08.090, 98-24-051, § 388-265-1500, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1500, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-442, 388-33-448 and 388-33-458.]

WAC 388-265-1600 Ending protective payee status and changing payees. A client may be removed from a protective payee when a:

(1) Protective payee requests the client be reassigned;

(2) Different protective payee is assigned; or

(3) Protective payee is no longer required.

[Statutory Authority: RCW 74.08.090, 98-24-051, § 388-265-1600, filed 11/25/98, effective 12/26/98; 94-10-065 (Order 3732), § 388-265-1600, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-33-446 and 388-33-457.]

WAC 388-265-1650 Protective payment—Fair hearing rights. With the exception of noncooperation with the office of support enforcement, a client has the right to a fair hearing if the client is:

(1) Dissatisfied with the department's decision that a protective payment shall be made, continued, or changed; or

(2) Dissatisfied with the protective payee selected.

[Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-265-1650, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-459.]

WAC 388-265-1750 Protective payee fees. (1) The department may authorize a fee to cover approved administrative costs of the protective payee under the following conditions:

(a) The person serving as protective payee is not a department employee; and

(b) The client is eligible for:

(i) GA-U;

(ii) TANF when the department has determined a client is unable to manage the client's assistance funds;

(iii) TANF when the department has determined a client is under sanction due to failure, without good cause, to participate in the jobs opportunity and basic skills training (JOBS) program; or

(iv) GA or TANF and is a pregnant or parenting minor, and protective payment established under RCW 74.04.0052 or RCW 71.12.255.

(2) The department shall not allow the protective payee to withhold money from the client's grant for payment of the protective payee's costs or services.

(3) "Administrative costs fee" means a fixed amount per assistance recipient, as set forth in the contract between the protective payee and the department.

[Statutory Authority: RCW 74.08.090 and 74.08.280, 97-13-091, § 388-265-1750, filed 6/18/97, effective 7/19/97. Statutory Authority: RCW 74.08.090, 1994 c 299 § 33, RCW 74.08.280 and 74.50.060(2), 95-11-119

(Order 3858), § 388-265-1750, filed 5/24/95, effective 6/24/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-265-1750, filed 5/3/94, effective 6/3/94. Formerly WAC 388-33-455 (part).]

Chapter 388-275 WAC

SUPPLEMENTAL SECURITY INCOME

WAC

388-275-0010	Purpose.
388-275-0040	Effect on other programs.
388-275-0080	Overpayment and underpayment.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-275-0020	Definitions. [Statutory Authority: RCW 74.08.090 and 74.04.600 through 74.04.650. 94-04-033 (Order 3695), § 388-275-0020, filed 1/26/94, effective 2/26/94.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-275-0030	Administrative responsibility. [Statutory Authority: RCW 74.08.090 and 74.04.600 through 74.04.650. 94-04-033 (Order 3695), § 388-275-0030, filed 1/26/94, effective 2/26/94.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-275-0050	Waiver of state supplement. [Statutory Authority: RCW 74.08.090 and 74.04.600 through 74.04.650. 94-04-033 (Order 3695), § 388-275-0050, filed 1/26/94, effective 2/26/94.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-275-0060	Payments. [Statutory Authority: RCW 74.08.090. 94-16-044 (Order 3759), § 388-275-0060, filed 7/27/94, effective 9/1/94. Statutory Authority: RCW 74.08.090 and 74.04.600 through 74.04.650. 94-04-033 (Order 3695), § 388-275-0060, filed 1/26/94, effective 2/26/94.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-275-0070	Termination of state supplement. [Statutory Authority: RCW 74.08.090 and 74.04.600 through 74.04.650. 94-04-033 (Order 3695), § 388-275-0070, filed 1/26/94, effective 2/26/94.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-275-0090	Representative payee. [Statutory Authority: RCW 74.08.090 and 74.04.600 through 74.04.650. 94-04-033 (Order 3695), § 388-275-0090, filed 1/26/94, effective 2/26/94.] Repealed by 98-16-044, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-275-0010 Purpose. The purpose of the Supplemental Security Income Program is to provide a minimum income level for persons who are aged, blind, and disabled with limited income and resources.

Authority for the program is found in Title XVI of the Social Security Act amended by P.L. 92-603.

[Statutory Authority: RCW 74.08.090 and 74.04.600 through 74.04.650. 94-04-033 (Order 3695), § 388-275-0010, filed 1/26/94, effective 2/26/94.]

WAC 388-275-0040 Effect on other programs. (1) SSA shall not pay the SSI ineligible spouse state supplement for a parent eligible for or receiving aid to families with dependent children (AFDC) for or with the parent's children.

(2) The department shall not pay state-funded general assistance when:

(a) The SSI eligible individual is eligible for or receiving an SSI ineligible spouse state supplement for the spouse; or

(b) The spouse of an SSI eligible individual refuses, without good cause, to apply for the SSI ineligible spouse state supplement.

[Statutory Authority: RCW 74.08.090 and 74.04.600 through 74.04.650. 94-04-033 (Order 3695), § 388-275-0040, filed 1/26/94, effective 2/26/94.]

WAC 388-275-0080 Overpayment and underpayment. (1) SSA recoupment procedures for SSI benefit amounts shall also apply to the recovery of state supplementary overpaid amounts.

(2) The department shall not compensate an SSI beneficiary for reductions of the beneficiary's SSI benefit or state supplement caused by recoupment procedures.

(3) SSA shall pay the claimant for a state supplementation underpayment; except when the:

(a) Claimant dies before receiving the underpaid amount, SSA shall pay the underpaid amount to the claimant's eligible spouse.

(b) Deceased claimant does not have an eligible spouse, no payment of the underpaid amount is made.

(4) General assistance that is subsequently duplicated by the client's receipt of SSI for the same period and not reimbursed to the state is considered a debt due the state and subject to recovery through all available legal remedies.

(a) The department shall establish a debt for general assistance not reimbursed except when the:

(i) Initial or reinstated SSI payment is sent to the department; and

(ii) SSI payment does not cover the amount of interim assistance issued.

(b) General assistance that is duplicated by emergency advance SSI payments or SSI payments based on presumptive disability or presumptive blindness is not recoverable from the interim assistance reimbursement payment and shall be considered a debt.

[Statutory Authority: RCW 74.08.090 and 74.04.600 through 74.04.650. 94-04-033 (Order 3695), § 388-275-0080, filed 1/26/94, effective 2/26/94.]

Chapter 388-280 WAC

UNITED STATES (U.S.) REPATRIATE PROGRAM

WAC

388-280-1010	Purpose.
388-280-1020	Definition.
388-280-1030	Application.
388-280-1040	Relying repatriation assistance.
388-280-1050	Safeguarding information.
388-280-1060	Referral to other agencies.
388-280-1070	Income and resources.
388-280-1080	Eligibility.
388-280-1090	Client responsibilities.
388-280-1100	Department responsibilities as the port of entry state.
388-280-1110	Department responsibilities as the final destination state.
388-280-1120	Unattended minors.
388-280-1130	Scope of services.
388-280-1140	Time limits on benefits.
388-280-1150	Payment limits.
388-280-1160	Assistance payment—Types of payments.

WAC 388-280-1010 Purpose. (1) The purpose of the program is to assist repatriates, returned or brought to the U.S. from foreign countries, to resettle in the U.S. by providing assistance for one year or less until other resources become available.

(2) Repatriation assistance is a loan which is to be repaid by the repatriate. Repayment is according to the repatriate's ability.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1010, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1020 Definition. (1) "Dependent of U.S. citizen" means:

(a) An adult repatriated U.S. citizen's:

(i) Spouse;

(ii) Unmarried minor children, including adopted and stepchildren;

(iii) Unmarried adult children with disabilities when dependency is based on the disability; or

(iv) Parents.

(b) A minor repatriated U.S. citizen's:

(i) Spouse;

(ii) Parents or grandparents; or

(iii) Minor siblings.

(c) A U.S. citizen's repatriated spouse's:

(i) Parents; or

(ii) Minor siblings.

(2) "Extended repatriation assistance" means repatriation assistance provided for up to nine months after eligibility for the ninety-day temporary assistance period ends.

(3) "Repatriate" means a U.S. citizen or a dependent of a U.S. citizen who is without available resources and is returned or brought back from a foreign country to the U.S. because of:

(a) Destitution of the U.S. citizen; or

(b) Illness of the U.S. citizen or the dependent of a U.S. citizen; or

(c) War, threat of war, invasion, or similar crisis.

(4) "Temporary assistance" means repatriation assistance provided during the first ninety days a repatriate is back in this country.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1020, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1030 Application. (1) The department shall consider a referral to a person by the U.S. State Department as a request for assistance.

(2) For client requests, where a person contacts the department directly, the department shall:

(a) Notify the U.S. State Department of such request;

(b) Consider the U.S. State Department's reply, designating the person as a repatriate, as a request for assistance.

(3) The department shall apply to the U.S. Department of Health and Human Services (HHS) for extended repatriation assistance when he repatriate is:

(a) Unable to attain self-support or self-care for reasons such as age, disability, or lack of vocational preparation; or

(b) Ineligible for assistance through any other program.

(4) When extended repatriation assistance is appropriate, the department shall apply for such assistance before the expiration of the initial ninety-day period of eligibility.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1030, filed 5/26/93, effective 6/26/93.]

(1999 Ed.)

WAC 388-280-1040 Repaying repatriation assistance. (1) The department shall:

(a) Explain to the repatriate that assistance received under the U.S. repatriate program is a loan the repatriate is expected to repay;

(b) Obtain a signed statement that the repatriate:

(i) Understands the repayment requirement; and

(ii) Agrees to make repayment;

(c) Assess the repatriate's ability to repay and make a recommendation to the U.S. Department HHS regarding the repatriate's financial ability to make repayment; and

(d) Document reasons why the repatriate is unable to make repayment.

(2) The department shall consider a repatriate able to repay assistance when income or resources in excess of continuing needs will become available within one year after the repatriate's resettlement.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1040, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1050 Safeguarding information. (1) The department shall use information obtained about a repatriate only as necessary for program administration.

(2) Except as noted under subsection (3) of this section, the department shall not disclose:

(a) The name or address of a repatriate, including lists or passenger manifests; or

(b) Personal information identifying a repatriate, the circumstances or physical or mental health as furnished on applications, reports of investigations, medical reports, or any other department records.

(3) The department may release personal information to another agency from whom the repatriate has requested services when:

(a) A repatriate receives a request for the release of relevant information from the other agency which specifies the other agency will not disclose the information.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1050, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1060 Referral to other agencies. The department shall refer a repatriate to the Social Security Administration to apply for Supplemental Security Income (SSI) benefits if the repatriate is:

(1) Sixty-five years of age or older;

(2) Blind; or

(3) Disabled.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1060, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1070 Income and resources. (1) The department may deny or terminate repatriate assistance when the client has nonexempt:

(a) Income, according to aid to families with dependent needs; and/or

(b) Resources, according to AFDC rules, that are immediately available to meet their repatriation needs.

(2) The department shall consider resources immediately available when the:

(a) Resource value can be determined;

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- (b) Resource is under the control of the repatriate; and
- (c) Repatriate can draw upon the resource for maintenance.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1070, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1080 Eligibility. Provided a household is otherwise eligible, the department shall grant:

(1) Temporary repatriation assistance to needy persons who are repatriates as designated by the U.S. State Department.

(2) Extended repatriation assistance to needy repatriates upon approval of the U.S. Department of Health and Human Services.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1080, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1090 Client responsibilities. An applicant for or recipient of repatriation assistance shall:

(1) Provide evidence the U.S. State Department needs to establish the applicant's status as a repatriate;

(2) Assist in determining the willingness and ability of a relative to assist the repatriate;

(3) Report other resources potentially available or self support; and

(4) Immediately report change in income or resources.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1090, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1100 Department responsibilities as the port of entry state. The department shall:

(1) Meet the repatriate at the port of entry and determine what services are needed;

(2) Explain the program and provide a repatriate with informational handouts as provided by the U.S. Department of HHS;

(3) Explain the repayment provisions for the program and secure a signed repayment agreement;

(4) Provide appropriate assistance including onward transportation to the final destination;

(5) Coordinate with the final destination state regarding reception and care at the final destination;

(6) For mentally ill repatriates, provide related hospitalization and other medical assistance, including involuntary treatment in a mental health hospital, as necessary.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1100, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1110 Department responsibilities as the final destination state. The department shall:

(1) Develop a plan to carry out arrangements for care, treatment, and assistance or reception, assistance, and resettlement;

(2) Determine the need for continuing assistance;

(3) Explain the program;

(4) Explain the repayment provisions and secure a signed repayment agreement; and

(5) Provide necessary services.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1110, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1120 Unattended minors. The department shall provide services for the care and protection of unattended repatriate minors. The department shall:

(1) Provide social services or arrange for placement of the repatriate minor in a facility that supplement or substitute for parental care and supervision, as needed, through the child welfare services program;

(2) Ensure such services and assistance conform to the department's standards for foster home, receiving home, or institutional care; and

(3) Observe recognized child welfare practices in protecting an unaccompanied repatriate minor.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1120, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1130 Scope of services. The department shall provide a repatriate the following necessary services:

(1) Transportation to the repatriate's place of residence, the home of relatives, or the place the repatriate will be resettled;

(a) Only one domestic trip is allowable;

(b) The lowest cost and most direct means of transportation unless effective service to a repatriate calls for other accommodations;

(c) Transportation expenses, including travel incidentals, such as meal and lodging enroute and assistance with luggage, checking, storage, or transportation of personal effects.

(2) Transportation, overnight accommodations, and per diem for an escort to accompany and assist a physically ill or mentally ill or disabled repatriate from the port of entry to the final destination, and the escort's expenses when returning to the port of entry;

(3) Food items to meet the cost of a physician-recommended special diet;

(4) Restaurant meals as required;

(5) Temporary shelter;

(6) Essential clothing;

(7) Medical and hospital care a physician considers necessary because of the repatriate's health. The department shall limit care provided by the port of entry state to acute illnesses which prevent the repatriate from traveling to the final destination state;

(8) Necessary social services;

(9) Subsistence and resettlement expenses;

(10) Communication by phone or telegraph to contact relatives, friends, or former employers to obtain access to resources for self-support;

(11) Housing arrangements to provide adequate accommodations, including housing or utility deposits;

(12) Sufficient funds for maintenance until the agency at the final destination can begin to assist the repatriate, if the person requires resettlement at the final destination; and

(13) Counseling and referral in regard to employment, and retaining.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1130, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1140 Time limits on benefits. (1) Except as provided under subsection (2) of this section, the

department shall limit repatriate assistance to ninety days beginning with the date of arrival in the U.S.

(2) The department shall provide a repatriate extended repatriation assistance for up to an additional nine months upon prior approval by the U.S. Department of Health and Human Services.

(3) The department shall immediately terminate a repatriate's assistance upon the repatriate's receipt of financial benefits under either the AFDC or SSI programs.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1140, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1150 Payment limits. (1) The department shall limit payments for repatriation assistance to:

(a) The department's payment standards for the AFDC program as appropriate for the number of eligible repatriates for ongoing assistance;

(b) A maximum of five hundred and sixty dollars per person for resettlement or assistance for initial one-time services such as rental deposits. The department shall limit use of this maximum to not more than one month and only during the temporary assistance period;

(2) The department's payment for other services shall be as provided under section 1130, "Scope of services" in this chapter.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1150, filed 5/26/93, effective 6/26/93.]

WAC 388-280-1160 Assistance payment—Types of payments. (1) The department shall grant a repatriate assistance in cash, voucher, or warrant. Payment shall be made either to the repatriate or in the repatriate's behalf.

(2) The department's method of payment shall be at the department's option.

[Statutory Authority: RCW 74.08.090. 93-12-054 (Order 3560), § 388-280-1160, filed 5/26/93, effective 6/26/93.]

Chapter 388-290 WAC SUBSIDIZED CHILD CARE

WAC

388-290-010	Subsidized child care—Purpose and income limit.
388-290-020	Subsidized child care—Definitions.
388-290-025	Subsidy units and copayments.
388-290-030	Responsibilities for the department, the consumer, and the provider under the subsidized child care program.
388-290-035	Providers eligible for payment under the subsidized child care program.
388-290-050	Eligible children and consumers under the subsidized child care program.
388-290-055	Payment for subsidized child care.
388-290-060	Adequate notice requirements and effective dates.
388-290-070	Self-employment and subsidized child care.
388-290-080	Subsidized child care—Fair hearings.
388-290-090	Subsidized child care—Income eligibility, copayments rates, and when to calculate copayments.
388-290-105	Subsidized child care—Overpayments.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-290-040	Assurances and responsibilities under JOBS, income assistance, and transitional child care. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-040, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed
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10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

JOBS, income assistance, and transitional child care programs. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-110, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

JOBS, income assistance, and transitional child care programs—Eligible children and recipients. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-115, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

JOBS, income assistance, and transitional child care program—Payment. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-120, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

JOBS, income assistance, and transitional child care programs—Effective dates. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-123, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

Income assistance and transitional child care programs—Effect on eligibility and payments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-130, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

JOBS, income assistance, and transitional child care—Hearings. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 96-09-058 (Order 3965), § 388-290-135, filed 4/12/96, effective 5/13/96; 95-23-028 (Order 3916), § 388-290-135, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

Income assistance child care program—Conversion. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-140, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

Transitional child care—Purpose and initial eligibility. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-155, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

Transitional child care—Co-payment. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-160, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

Transitional child care—Ongoing eligibility. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-170, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

Child care overpayments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-180, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

Other supportive services. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-210, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.

Transitional supportive services. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-250, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effec-

388-290-260 tive 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.
Supportive services overpayments. [Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-260, filed 11/8/95, effective 12/9/95.] Repealed by 97-20-130, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404.]

WAC 388-290-010 Subsidized child care—Purpose and income limit. The purpose of this program is to provide child care services necessary to assist families with dependent children to become or remain employed. The department may provide subsidized child care services to families with incomes at or below one hundred seventy-five percent of the Federal Poverty Level (FPL) adjusted for family size.

[Statutory Authority: RCW 74.04.050. 98-21-005, § 388-290-010, filed 10/9/98, effective 11/9/98. Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-020, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-010, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-010, filed 11/8/95, effective 12/9/95.]

WAC 388-290-020 Subsidized child care—Definitions. Except as specified in this chapter, terms used under chapter 388-290 WAC shall have the same meaning as in the WorkFirst and TANF programs.

"Able" means an adult physically, mentally, and emotionally capable of caring for a child in a responsible manner.

"Adjusted earned income" means the gross earned income minus the average payroll and income tax paid at that income level.

"Available" means an adult able to provide care due to not participating in an approved WorkFirst activity and/or employment during the time child care is needed.

"Consumer," for the purposes of this chapter, means [a]:

- (1) A child's parent; or
- (2) Relative in WAC 388-215-1080 (Living in the home of a relative of specified degree—Nonparental relative defined), who:
 - (a) Has parental control; and
 - (b) Applies for, or receives subsidized child care services funded by the department.

"In-home/relative provider" means an unlicensed child care provider who is:

- (1) One of the following adult relatives providing care in either the child's or relative's home:
 - (a) An adult sibling living outside the child's home; or
 - (b) A grandparent, aunt, uncle, first cousin, or great-grandparent, great-aunt, or great-uncle; and
 - (c) Not the child's biological, adoptive, or stepmother or stepfather.
- (2) An adult friend or neighbor providing care in the child's own home; or

(3) An adult extended tribal family member as defined under chapter 74.15 RCW (Care of children, expectant mothers, developmentally disabled) who is providing care.

"Parent" for the purposes of this chapter, means a parent by blood, marriage, or adoption, or a legal guardian.

"Subsidy unit" for the purposes of this chapter, means child care assistance unit.

"Total income," for the purposes of this chapter, means the sum of adjusted earned income and unearned income.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-020, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-020, filed 10/1/97, effective 11/1/97. Statutory Authority: RCW 74.04.050 and 45 CFR 255.4(F). 95-23-028 (Order 3916), § 388-290-020, filed 11/8/95, effective 12/9/95.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-290-025 Subsidy units and copayments.

(1) Only individuals residing in the same household can be included in subsidy unit size.

(2) The minimum copayment is assessed for minor parents who are:

(a) Receiving TANF and living independently;

(b) The TANF head of household;

(c) Part of another TANF grant.

(3) The department can assess copayments above the minimum for:

(a) Related adults, other than spouses, and their respective child(ren). These are each separate subsidy units.

(b) Unmarried parents with a mutual child(ren). This is a single subsidy unit.

(c) Married parents with or without a mutual child(ren). This is a single subsidy unit.

(d) Married or unmarried parents and their mutual and nonmutual children, if there is at least one mutual child. This is a single subsidy unit.

(e) Unmarried adults without a mutual child(ren). These are each separate subsidy units.

(f) A non-TANF minor parent living independently. This is a single subsidy unit.

(g) A child or minor parent living with a legally nonresponsible caretaker. This is a separate subsidy unit.

(4) Eligibility for subsidized child care ends when the consumer fails to pay, or arrange payment for, required copayment fees.

(5) The department reinstates the subsidy unit's eligibility for subsidized child care when back copayment fees are paid or satisfactory arrangements are made to make full payments.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-025, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-025, filed 10/1/97, effective 11/1/97.]

WAC 388-290-030 Responsibilities for the department, the consumer, and the provider under the subsidized child care program. (1) The department provides a program of subsidized child care for income-eligible consumers as follows:

(a) Only authorize payment to child care providers who allow parents or guardians access to their children whenever the children are in care;

- (b) Take the child's needs into account when the department authorizes child care;
- (c) Assure the parent's choice of child care facility or provider is protected;
- (d) Only authorize payment when no adult in the subsidy unit is able and available to care for the children;
- (e) Respond to requests for subsidized child care within ten days;
- (f) Inform consumers of the child care options for which the department can make payment;
- (g) Inform consumers of community resources which can help them select child care, if needed;
- (h) Inform consumers of their rights and responsibilities in relation to child care; and
- (i) Provide prompt child care payments to the provider.

(2) Consumers will:

- (a) Be responsible to choose the provider and make the child care arrangements, including backup care arrangements;
- (b) Notify the department of any change in providers within ten days;
- (c) Pay the in-home/relative provider after the department pays the consumer for in-home/relative care;
- (d) Be responsible to pay, or make arrangements to pay, any required copayment directly to the child care provider;
- (e) Supply the department with necessary information to allow payment to the authorized provider;
- (f) Notify the provider within ten days when the department discontinues or changes the child care authorization;
- (g) Provide notice to the department within ten days of any change in household size or income level; and
- (h) Assure the in-home/relative provider furnishes a valid social security number to the department, if the consumer chooses this kind of provider.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-030, filed 10/1/97, effective 11/1/97.]

WAC 388-290-035 Providers eligible for payment under the subsidized child care program. (1) A licensed child care provider must be licensed as required by chapter 74.15 RCW and chapters 388-73, 388-155 (Minimum licensing requirements for family child day care homes), or 388-150 WAC (Minimum licensing requirements for child day care centers).

- (2) Child care providers exempt from licensing but who must be certified by the department include:
 - (a) Tribal child care facilities meeting the requirements of tribal law;
 - (b) Child care facilities on a military installation;
 - (c) Child care facilities operated on public school property by a school district.
- (3) In-home/relative providers are exempt from licensing and certification, but must be registered with the department and meet the requirements of WAC 388-15-170.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-035, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-035, filed 10/1/97, effective 11/1/97.]

(1999 Ed.)

WAC 388-290-050 Eligible children and consumers under the subsidized child care program. (1) To be eligible for subsidized child care, the consumer must:

- (a) Be a caretaker of one or more children; and
- (b) Not care for their own child(ren) during the time child care is authorized, if the consumer is an employee of the child care facility to which the department has authorized payment.

(2) The department may authorize subsidized child care for a child between thirteen and nineteen years old if the child is:

- (a) Under court supervision;
- (b) Physically, mentally or emotionally incapable of self-care. This must be verified by a licensed medical practitioner or masters-level or above mental health professional.

(3) The department may authorize special needs child care for children under thirteen years old if the conditions in subsection (2)(b) of this section are met.

(4) TANF consumers in sanction are not eligible for subsidized child care unless child care is necessary to:

- (a) Obtain or maintain employment;
- (b) Enroll in, or maintain enrollment in, an approved WorkFirst activity; or
- (c) Remove the sanction.

(5) The child(ren) for whom the consumer applies must be a citizen or legally residing in the country.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-050, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-050, filed 10/1/97, effective 11/1/97.]

WAC 388-290-055 Payment for subsidized child care. (1) The department pays for child care for:

(a) A consumer's hours of participation in an approved WorkFirst activity and/or hours of employment;

(b) Transportation time between the place of employment or approved WorkFirst activity and the location of child care, if needed;

(c) Self-employment under WAC 388-290-070;

(d) A consumer's hours of participation in education and training programs for up to thirty-six months total, including up to twelve months while on TANF if:

(i) The education and training programs are adult basic education (ABE), English as a second language (ESL), high-school/GED, or vocational education and job skills training as defined under chapter 388-310 WAC; and

(ii) The consumer is working twenty hours or more per week and does not have a prior approved JOBS plan.

(e) Education and training programs for TANF consumers who:

(i) Have prior approved JOBS plans; and

(ii) Are working at least twenty hours per week.

(f) A consumer's hours of participation in an employment retention activity if:

(i) The consumer is a TANF recipient working twenty hours or more per week. Child care may be authorized as needed;

(ii) The consumer is a former TANF recipient working twenty hours or more each week and earning below one hundred seventy-five percent of the FPL. Child care may be

authorized for up to one year following the consumer's exit from TANF.

(g) A consumer's hours of participation in a labor exchange activity if:

(i) The consumer is a TANF recipient working twenty hours or more each week. Child care may be authorized as needed;

(ii) The consumer is a former TANF recipient working twenty hours or more each week and earning below one hundred seventy-five percent of the FPL. Child care may be authorized for up to two years following the consumer's exit from TANF.

(2) Consumers under subsection (1)(d) and (e) of this section, must be making satisfactory progress in their education or training programs.

(3) The department may authorize child care payments for up to two weeks for a TANF consumer waiting to enter an approved WorkFirst activity.

(4) The department may authorize child care payments for up to four weeks for a consumer who experiences a gap in employment, or approved WorkFirst activity, if all the following conditions are met:

(a) The gap is for reasons out of the consumer's control;

(b) Employment, or the approved WorkFirst activity, will resume within that period or the consumer is looking for alternate employment; and

(c) The consumer received subsidized child care immediately before the gap in employment, or approved WorkFirst activity.

(5) The department pays initial and ongoing annual registration/equipment fees only if the fees are:

(a) Required of all parents whose child(ren) are in care with that provider; and

(b) Needed to maintain a child care arrangement.

(6) The department may pay ongoing activity fees to the child care provider if the conditions in subsection (5)(a) and (b) of this section are met.

(7) The department may pay child care providers a one-time bonus for each infant they newly enroll into care if the following conditions are met:

(a) The child who is being cared for is an infant less than twelve months of age; and

(b) The child care provider is licensed by the department as required by chapters 388-73, 388-150 or 388-155 WAC; and

(c) Care is provided for a minimum of five days.

(8) The department may establish a protective payee due to mismanagement of funds for consumers who fail to pay the in-home/relative child care provider, when:

(a) The department issued a child care warrant to the correct address and twelve or more working days have passed since the issuance date; and

(b) The consumer has not reported the warrant lost, stolen, or destroyed.

[Statutory Authority: RCW 74.04.050, 98-21-005, § 388-290-055, filed 10/9/98, effective 11/1/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404, 97-20-130, § 388-290-055, filed 10/1/97, effective 11/1/97.]

WAC 388-290-060 Adequate notice requirements and effective dates. (1) The department authorizes subsidized child care payments effective the following dates:

(a) For TANF consumers, the date an approved WorkFirst activity begins, or the date of request for TANF assistance, whichever is later.

(b) For non-TANF consumers, the date employment begins, or the date of request for child care, whichever is later.

(2) The department provides advance and adequate notice to consumers for changes in payment when the change results in a discontinuation, suspension, reduction, termination, or forces a change in child care arrangements.

(3) Advance and adequate notice requirements do not apply for other changes in the manner of payment.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404, 97-20-130, § 388-290-060, filed 10/1/97, effective 11/1/97.]

WAC 388-290-070 Self-employment and subsidized child care. (1) To be and remain eligible for subsidized child care, a self-employed person must maintain and make available to the department a record which clearly documents all claimed business expenses and income.

(2) For the first twelve months of self-employment starting from the date the consumer first became eligible for child care for self-employment, the consumer's required hours of child care are based on the greater of the following:

(a) Written documentation of the number of hours needed based on hours worked, as approved by the department; or

(b) The number of hours calculated by dividing the consumer's monthly self-employment income by the federal minimum wage.

(3) After the first twelve months, the consumer's necessary hours of child care are based on the lesser amount in subsection (2)(a) or (b) of this section.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404, 97-20-130, § 388-290-070, filed 10/1/97, effective 11/1/97.]

WAC 388-290-080 Subsidized child care—Fair hearings. (1) Consumers may request fair hearings under chapter 388-08 WAC (Practice and procedure—Fair hearing) on any action affecting child care benefits except for changes resulting from a change in policy or law.

(2) Consumers of subsidized child care may be eligible for continued child care benefits pending the outcome of a fair hearing if the consumer requests the fair hearing on or before the effective date of the action or within ten days of the notice of adverse action.

(3) The department shall consider any child care benefits the consumer receives pending a fair hearing or hearing decision to be an overpayment if the fair hearing decision subsequently finds against the consumer.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404, 97-20-130, § 388-290-080, filed 10/1/97, effective 11/1/97.]

WAC 388-290-090 Subsidized child care—Income eligibility, copayments rates, and when to calculate copayments. (1) The department determines income eligibility for subsidized child care as follows:

(a) By using the best available evidence of the subsidy unit's current and expected income, except for income types in WAC 388-290-090 (1)(c);

(b) By counting:

(i) The military family's housing and food allowance as adjusted earned income;

(ii) A consumer's in-kind income as adjusted earned income.

(c) By exempting:

(i) Income types in WAC 388-218-1200 (Exempt income types), except for SSI income, which is counted, WAC 388-218-1210 (Exempt and disregarded income—educational assistance), 388-218-1220 (Disregarded income—Native American benefits), and 388-218-1230 (2) through (7) (Disregarded income types);

(ii) The earned income of a child, unless otherwise indicated in WAC 388-290-025(3); and

(iii) The TANF grant for the first three consecutive calendar months after the TANF consumer starts a new job. The first calendar month is the month in which the consumer starts employment. This exemption can be applied once every six months.

(2) All consumers contribute to the subsidized child care cost by making monthly copayments, as follows:

(a) Ten dollars for subsidy units with total income at or below seventy-four percent of the Federal Poverty Level (FPL);

(b) Twenty dollars for subsidy unit with total income above seventy-four percent and up to one hundred percent of the FPL;

(c) Subsidy units with total income over one hundred percent of the FPL pay the greater of:

(i) Twenty dollars; or

(ii) Forty-seven percent of total income exceeding one hundred percent of the FPL.

(3) The department calculates copayments:

(a) At the time of the initial eligibility determination or authorization;

(b) At least every six months, starting from the first month of eligibility;

(c) When monthly income increases one hundred dollars or more;

(d) When monthly income decreases, except as indicated in subsection (4) of this section; or

(e) When subsidy unit size changes.

(4) A consumer's copayment cannot decrease because of a reduction in the TANF grant due to a sanction.

(5) The department authorizes subsidized child care for up to six months at a time.

[Statutory Authority: RCW 74.04.050, 74.13.0903, and Public Law 104-193, Sections 407 and 605. 98-08-021, § 388-290-090, filed 3/19/98, effective 4/19/98. Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-090, filed 10/1/97, effective 11/1/97.]

WAC 388-290-105 Subsidized child care—Overpayments. (1) In areas not covered by this section, child care consumers are subject to chapter 388-270 WAC (Incorrect payments).

(1999 Ed.)

(2) When establishing an overpayment, the department reduces child care overpayment by the amount of a child care underpayment when applicable.

(3) When a provider receives payment for child care services not provided, the department establishes the overpayment in the provider's name.

(4) The department recovers overpayments in cases:

(a) Of fraud;

(b) Involving current or past consumers; and

(c) Where cost of recovery does not exceed the overpayment amount.

(5) The department may recover child care overpayments from current TANF or non-TANF consumers from their child care benefits. Recovery may not interfere with child care arrangements.

(6) The department may recover child care overpayments from TANF benefits on voluntary request of the TANF recipient.

[Statutory Authority: RCW 74.04.050 and 1997 c 58 §§ 401-404. 97-20-130, § 388-290-105, filed 10/1/97, effective 11/1/97.]

Chapter 388-310 WAC WORKFIRST

WAC

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WAC 388-310-0100 WorkFirst—Authority and purpose. (1) The WorkFirst program is established under Title 74 RCW.

(2) The goals of WorkFirst are to:

(a) Reduce poverty by helping those receiving temporary assistance for needy families (TANF) and state family assistance (SFA) get and keep jobs;

(b) Sustain the independence of those who become employed by helping them keep jobs; and

(c) Protect children and other vulnerable residents.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0200 WorkFirst—Components.

Except as otherwise specified, the terms used in this chapter, 388-310 WAC, shall have the same meaning as applied to the TANF program, and terms defined under chapter 388-22 WAC.

WorkFirst components are:

(1) **Paid employment**, either:

(a) Unsubsidized, including self-employment; or

(b) Subsidized and includes on-the-job training, work-study, and wage subsidy programs.

(2) **Work experience**;

(3) **Community service**;

(4) **Job search**;

(5) **Vocational educational training**;

(6) **Basic education activities**;

(7) **Post-employment services** which include employment retention and career development services.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0200, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0300 WorkFirst—Participation exemptions. (1) All TANF and state family assistance (SFA) recipients who are sixteen years of age and older and all custodial parents are required to participate in WorkFirst unless exempted under subsection (2)(a) of this section.

(2) A person is exempt from WorkFirst participation requirements if:

(a) The person is needed in the home to personally provide care for a child under twelve months of age.

(b) The person may use this exempt status for a total of twelve months during the person's sixty-month lifetime limit for assistance.

(3) Persons who are exempt may volunteer to participate and will not be subject to sanction for subsequent refusal to participate if still eligible for the exemption.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0300, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0400 WorkFirst—What are the initial requirements of a WorkFirst participant? (1) WorkFirst requires you to look for a job as your first activity unless you are temporarily deferred from job search. Reasons that you may be temporarily deferred from looking for a job are:

(a) You work twenty or more hours a week; "work" means to engage in any legal, income generating activity which is taxable under the United States Tax Code or which would be taxable with or without a treaty between an Indian Nation and the United States; or

(b) You are under the age of eighteen and have not completed high school or GED; or

(c) You are under the age of twenty, and are attending high school or an equivalent full-time; or

(d) Your situation prevents you from looking for a job (see WAC 388-310-1600).

(2) If and when your job search is temporarily deferred, you must take part in an evaluation of your employability as part of your individual responsibility plan (IRP).

(3) You must follow instructions from your case manager and/or job service specialist as written in your IRP.

(4) If you do not participate in job search, or in the activities listed in your IRP during your temporary deferral from job search, and you do not have a good reason, the department will impose a financial penalty, sometimes called a sanction.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 98-23-037, § 388-310-0400, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0400, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0500 WorkFirst—What is included in WorkFirst job search? (1) Job search is an opportunity to learn and use skills you need to find and keep a job. Job search may include:

(a) Classroom instruction; and/or

(b) Structured job search that helps you find job openings, complete applications, practice interviews and apply other skills and abilities with a job search specialist or a group of fellow job-seekers; and/or

(c) Pre-employment training, in which you learn skills you need for an identified entry level job that pays more than average entry level wages. Pre-employment training is an acceptable job search activity when an employer or industry commits to hiring or giving hiring preference to WorkFirst participants who successfully complete pre-employment training.

(2) WorkFirst job search is delivered by the employment security department or a contracted partner.

(3) Period of job search may last up to twelve continuous weeks. Job search specialists will monitor your progress, and by the end of the first four weeks, job search specialists will determine whether or not you should continue in job search. Job search will end when:

(a) You find a job; or

(b) You become exempt from WorkFirst requirements (see WAC 388-310-0300); or

(c) Your situation changes and you are temporarily deferred from continuing with job search (see WAC 388-310-0400); or

(d) Job search specialists have determined that you need additional skills and/or experience to find a job.

(4) At the end of the job search period, you will be referred back to your DSHS case manager for further action.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 98-23-037, § 388-310-0500, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-0500, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0600 WorkFirst—Evaluation of employability. (1) A participant's employability will be evaluated by the department when:

(a) The person has not obtained paid, unsubsidized employment at the conclusion of job search; or

(b) The person was not referred for immediate job search.

(2) The purpose of the employability evaluation process is to determine:

(a) The reasons why a person is unable to find work in the local labor market; and

(b) Which WorkFirst components, support services, or child care services are needed by the participant to become employed in the shortest time possible.

(3) The evaluation will be focused on factors related to the person's ability to find and retain employment in the local labor market.

(4) Information gathered in the evaluation will be the basis for modifying the participant's individual responsibility plan.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0700 WorkFirst—Individual responsibility plan. (1) The purpose of the individual responsibility plan is to set forth:

(a) The participant's responsibility to participate in the WorkFirst components as required;

(b) The services the department will provide to the person to enable the person to participate.

(2) The department and the participant will work together in the development and decision-making process for component assignment. If needed, the department may assign the component which will provide the person with the job search, work experience, job skills, substance abuse assessment and treatment, family counseling, or family violence counseling or housing search, acquisition, and stabilization assistance as necessary to be employed in the shortest possible time.

(3) The plan includes the following:

(a) The WorkFirst component, in which participation is required, for what period of time and for how many hours a week;

(b) Any specific requirements relating to participation in the component;

(c) The services the department has determined are necessary for the person to participate in the component which may include provision of direct component cost funding, support services and child care subsidies.

(d) The participant's acknowledgement of their obligations to become and remain employed as quickly as possible.

(4) The department will review the elements in a participant's individual responsibility plan as necessary to ensure the plan continues to meet the person's employability needs.

(5) The participant will sign and receive a copy of their individual responsibility plan at the time the plan is developed and whenever the plan is modified.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0700, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0800 WorkFirst—Support service and direct component cost funding. (1) The purpose of support service and direct component cost funding is to provide participants access to necessary goods or services which cannot be paid for by another funding source.

(2) The department or its agent will fund support services when:

(a) Determined necessary by the department or its agent;

(b) Denial would prevent participation in the required component; and

(c) It is within available funds.

(3) Support services which may be funded include:

(a) Employment related needs such as work clothing or uniforms, tools, equipment, relocation expenses, or fees;

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(b) Transportation costs such as mileage reimbursement, public transportation vouchers, and car repair;

(c) Professional services such as certification or diagnostic testing, counseling or medical examinations or services;

(d) Personal needs such as clothing appropriate for job search or other component activities; and

(e) Special needs such as accommodations for employment.

(4) The department will provide support services and direct component cost funding to support components approved prior to the effective date of this chapter until June 30, 1998 if the participant is making satisfactory progress toward completion of the activity.

(5) WorkFirst participants are eligible for child care subsidy payments under chapter 388-290 WAC.

(6) No funds available to carry out the WorkFirst program may be used to assist, promote, or deter religious activity.

(7) The department may establish maximum funding limits for support services.

(8) The department may provide funding for direct component costs for vocational education activities when the participant:

(a) Is in an approved component as stated on the individual responsibility plan; and

(b) Does not qualify for sufficient student financial aid to meet the cost.

(9) Support services may be identified and provided in order to address specific needs American Indians may have due to location or employment needs.

(10) If the person is not participating as required they will lose eligibility for direct component costs and support services.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-0900 WorkFirst—Basic education. (1) Basic education is high school completion and classes to prepare for and testing to acquire GED certification. It may include adult basic education (ABE) or English as a second language (ESL) training if:

(a) The ABE or ESL is needed by the person to meet the current standards of the local labor market; and

(b) The activity is combined with paid or unpaid employment or job search.

(2) The department may require a nonexempt custodial parent eighteen and nineteen years of age who lacks a high school diploma or GED certification to participate in basic education if such education is needed by the person to meet the current standards of the local labor market.

(3) Nonexempt participants twenty years of age and older may participate in basic education activities but must also participate in paid or unpaid employment or job search for a minimum of twenty hours a week in addition to the basic education.

(4) The department may require sixteen and seventeen year old TANF and SFA recipients to be in high school or GED certification programs.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-0900, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1000 WorkFirst—What are the requirements for vocational education in WorkFirst? (1) Vocational education is training leading to a degree or certificate in a specific occupation, offered by accredited public and private technical colleges and schools, community colleges, and tribal colleges.

(2) WorkFirst may include vocational education in your IRP if:

- (a) You are working twenty or more hours a week; or
- (b) You lack job skills that are in demand for entry level jobs in your area; **and**
- (c) The vocational education program can provide the job skills that you need to qualify for entry level jobs in your area; **and**
- (d) You could not learn the job skills that you need to qualify for entry level jobs in your area by participating in work experience or on-the-job training that is available to you.

(3) When vocational education is included in your IRP, WorkFirst will provide assistance with your costs, if you need assistance and it is not available from other sources. Child care subsidy is available through the working connections child care program.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 98-23-037, § 388-310-1000, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1000, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1050 WorkFirst—What are the requirements for job skills training in WorkFirst? (1) Job skills training is training in specific skills directly related to employment, offered through community-based organizations, businesses, tribal governments, public and private community and technical colleges. Job skills training programs differ as to length, content, and sponsor.

(2) WorkFirst may include job skills training in your IRP if:

- (a) You are working twenty or more hours a week; **or**
- (b) You lack job skills that are in demand for entry level jobs in your area; **and**
- (c) The job skills training program can provide the job skills that you need to qualify for entry level jobs in your area; **and**
- (d) You could not learn the job skills that you need to qualify for entry level jobs in your area by participating in work experience or on-the-job training that is available to you.

(3) When job skills training is included in your IRP, WorkFirst will provide assistance with your costs, such as transportation and books, if you need assistance and it is not available from other sources. Child care subsidy is available through the working connections child care program.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 98-23-037, § 388-310-1050, filed 11/10/98, effective 12/11/98.]

WAC 388-310-1100 WorkFirst—Work experience. (1) Work experience (WEX) is unpaid work with a private nonprofit organization, federal, state, local or tribal government or district. Entities providing WEX unpaid employment positions to WorkFirst participants must be in compliance

with all applicable state and federal health and safety standards.

(2) The purpose of WEX is to provide the participant with instruction in essential work practices and to practice or expand work skills.

(3) Participant may be required to conduct a self-directed job search.

(4) Participants must accept offered paid employment while participating in WEX.

(5) A person's assignment to a specific WEX activity in excess of six months requires a department review. The review will determine if the person requires more time to gain the skills and abilities established as the desired outcome of the WEX assignment.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1100, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1200 WorkFirst—On-the-job training. (1) On-the-job training (OJT) is skills training provided by an employer at the employer's place of business. It may include some classroom training release time.

(2) A participant may be eligible for OJT employment if:

- (a) The person lacks skills which are in demand in the local labor market; **and**
- (b) There are employers in the area able to provide the training.

(3) An employer providing OJT may be reimbursed for up to fifty percent of the total gross wages for regular hours of work and pre-approved release time for training.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1200, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1300 Community jobs wage subsidy program. The community jobs wage subsidy program is to allow participants to gain skills and experience in a temporary position which helps them move into unsubsidized employment as quickly as possible. In all instances, the term 'department' refers to the department of social and health services (DSHS). The state department of community, trade and economic development (DCTED) administers the community jobs program. DCTED selects community jobs contractors (CJC) by using a competitive "requests for proposal" (RFP) process. DCTED, based upon the successful proposals, develops contracts specific to each selected community jobs contractor.

(1) WorkFirst case managers may assign a TANF/SFA participant to a community jobs (CJ) position when:

- (a) The participant has an unsuccessful job search;
- (b) The case manager determines the participant needs a supportive work environment to help them become more employable; **and**

(c) The participant's monthly cash grant is sufficient to pay their community jobs wages for twenty hours per week at the federal minimum wage.

(2) The department uses a participant's grant to provide a wage subsidy to the community jobs contractor.

(3) The CJs develop and manage the CJ positions, pay the wages and provide support services.

(4) Once hired, the department will authorize the participant's wage subsidy for no longer than nine TANF/SFA payment months in that specific position.

(5) CJC's may not hire participants into a community jobs position to do work related to religious, electoral or partisan political activities.

(6) Community jobs participants are employees of the community jobs contractor(s).

(7) Wages from the community jobs wage subsidy program are fully attributable to diverted public assistance funds. These wages are not "earned income" for purposes of eligibility for the WorkFirst fifty percent-earned income disregard. For the food stamp program, consider these wages and any grant supplement as TANF grant monies.

(8) The department shall review the appropriateness for continued participation in a community jobs position every ninety days during the nine-month placement. This review shall include:

(a) A review of any earned or unearned income received by the participant or other member of the assistance unit; and

(b) A review of continued TANF/SFA eligibility.

(9) Community jobs participants work an average of twenty hours per week at a gross wage of four hundred forty-two dollars and ninety cents per month, which is at least equal to the federal minimum wage. CJ participants are eligible for a twenty percent "work expense" income disregard applied to their gross pay for DSHS purposes when determining TANF/SFA residual grant amounts. In no instance may the net wages earned in a community jobs position exceed the participant's authorized TANF/SFA monthly grant amount.

(10) Community jobs participants earn sick leave and annual leave according to the rates designated for part-time employment by their employer (community jobs contractor). If the employer has no guidelines, participants earn sick leave at a rate of four hours each month and vacation leave at a rate of four hours each month. If they exhaust all leave and miss work time, a community jobs participant is expected to make up the missed time; total work is not to exceed forty hours per week. There is no cash-out value to the participant for accrued sick and vacation leave hours remaining at the end of the community jobs assignment.

(11) The amount of the CJ participant's TANF/SFA monthly grant shall be determined as stated in WAC 388-218-1390(2).

(12) Only those employers who take actions that enable a participant to move into other unsubsidized employment will be considered for additional subsidized employees.

(13) The following categories of employers will be considered for employment sites for participants in the community jobs wage subsidy program:

(a) Federal, state or local governmental agencies, and tribal governments; and

(b) Private and tribal nonprofit businesses, charities, and educational institutions.

[Statutory Authority: RCW 74.08.090, 74.04.050 and RCW 74.08A.320. 98-10-054, § 388-310-1300, filed 4/30/98, effective 5/31/98.]

WAC 388-310-1400 WorkFirst—Community service program. (1) Community service is:

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(a) Unpaid work performed for a charitable nonprofit organization, federal, state, local, or tribal government or district such as the work performed by volunteer workers; or

(b) An activity approved by the department which benefits the person, the person's family, or the person's community or tribe. These activities may include traditional activities that perpetuate tribal culture and customs.

(2) Activities which may be approved by the department under subsection (1)(b) of this section as part of the individual responsibility plan include:

(a) Caring for a disabled family member;

(b) Nonparental caretaker relative over age fifty caring for a child;

(c) Provision of child care for a WorkFirst participant by a WorkFirst participant;

(d) Active participation in a drug or alcohol assessment or treatment program certified or contracted through chapter 70.96A RCW;

(e) Specialized services as required by the participant to become employable or retain employment such as family violence counseling or active participation in a drug or alcohol assessment or treatment program certified or contracted through chapter 70.96A RCW.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1400, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1500 WorkFirst—Employment conditions. (1) Participants will not be required to accept paid or unpaid employment or engage in an activity in which an employer-employee relationship exists which:

(a) Is not covered by industrial insurance under Title 51 RCW, unless the employee is employed by a tribal government or a tribal private, for-profit business;

(b) Is available because of a labor dispute;

(c) Has working hours or other conditions which interfere with the participant's bona fide religious beliefs or observations;

(d) Involves conditions which are in violation of federal, state or tribal health and safety standards;

(e) Has unreasonable work demands or conditions, such as working without getting paid on schedule with regard to paid work; or

(f) Participants will not be required to participate in unpaid work components for more hours than would equal the family's TANF/SFA grant divided by state or federal minimum wage, whichever is higher. For two-parent families in which both parents are nonexempt, the combined hours of required participation in unpaid work may not exceed the family's TANF/SFA grant divided by the higher of the state or federal minimum wage.

(2) Participants will not be required to accept paid employment when the conditions of employment or the employer:

(a) Pays less than the federal, state, or tribe minimum wage, whichever is higher;

(b) Does not provide unemployment compensation coverage under Title 50 RCW, unless the employee is employed by a tribal government, tribal private for-profit business or the employee is exempt under section 7873 of the Internal

Revenue Code because the person is a treaty fishing rights related worker;

(c) Requires the person to resign from or refrain from joining a legitimate labor organization; or

(d) Does not provide benefits to participants equal to those provided to other similarly employed workers.

(3) Nothing contained herein shall be in violation of federal or tribal employment laws.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1500, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1600 WorkFirst—What are the WorkFirst participation requirements and what happens when a person does not participate? (1) To participate means that you give the department information requested from you, come to appointments made for you by the department and its agents, do all of the activities listed on your IRP and accept any bona fide offer of employment that you receive.

(2) If you do not participate, WorkFirst will ask you to explain why. The department will determine that:

(a) You had an adequate reason that you were not able to participate; or

(b) You did not have an adequate reason and that you refused to participate.

If the department is not able to contact you, the department will make this decision with the information already on hand.

(3) You have an adequate reason not to participate when you can show that an event outside of your control made you unable to participate. Such events include, but are not limited to:

(a) You, your child(ren), or other family member was ill;

(b) Support services (such as transportation) broke down and you could not make new arrangements right away;

(c) You could not locate care for your child(ren) under thirteen years that is affordable, appropriate, and within a reasonable distance;

"Affordable" means at or below your share of child care costs calculated by the working connections child care program.

"Appropriate" means licensed, certified or approved under state laws and regulations that apply to the type of child care you use, and that you may make your own choice among the child care options that are available in your area.

"Within a reasonable distance" means that you can reach the child care site without travel that exceeds normal expectations in your community.

(d) You could not locate other care services for an incapacitated individual living with you and your dependent child(ren);

(e) You have or had a physical, mental, or emotional condition, determined by a licensed health care professional, that interferes or interfered with your ability to participate;

(f) A significant person in your life died;

(g) You were threatened with or subjected to family violence;

(h) You had received an eviction notice or had another immediate legal problem;

(i) You did not receive notice of a request for information, an appointment or a requirement on your IRP.

(4) If you have an adequate reason that you did not participate, the department will revise your IRP to take your circumstances into account.

(5) If you do not have an adequate reason that you did not participate, the department will find that you refused to participate. The department will notify you that you will be sanctioned starting the next calendar month (see WAC 388-310-1700), unless you start to participate as required. The notice will include information on how to request a fair hearing if you disagree with the department's decision that you refused to participate.

[Statutory Authority: RCW 74.04.050 and 74.08.090. 98-23-037, § 388-310-1600, filed 11/10/98, effective 12/11/98; 97-20-129, § 388-310-1600, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1700 WorkFirst—Sanctions. (1) Refusal to participate will result in sanction.

(2) Sanction for refusing to participate will affect the family's TANF/SFA grant as follows:

(a) For the first month a person is sanctioned the family's TANF/SFA grant amount (less any income deductions) will be reduced by the participant's share.

(b) For second and subsequent months of continuous sanction status a protective payee will be established for reduced grant amount established under subsection (2)(a) of this section.

(c) For the third and subsequent months of continuous sanctions status the family's grant (less any income deductions) will be reduced by the amount established under subsection (2)(a) of this section or by forty percent whichever is higher. The protective payee will continue.

(3) The department will restore the full TANF/SFA grant amount retroactive to the day the participant begins or resumes participation in the component specified on the person's individual responsibility plan when the person meets participation requirements for the component for a minimum of two weeks.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1700, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1800 WorkFirst—Displacement of regular employees. (1) A person is not required to participate in subsidized employment or unpaid work activities which:

(a) Result in the displacement of any currently employed worker including partial displacement, such as reduction in hours of overtime or nonovertime work, reduction in wages, or employment benefits;

(b) Impair existing contracts for services or collective bargaining agreements;

(c) Result in the employment or assignment of a participant or the filling of a position when:

(i) Any other person is on layoff from the same or a substantially equivalent job within the same organizational unit; or

(ii) An employer has created a vacancy for the purpose of hiring a WorkFirst participant by terminating any regular employee or otherwise reduced its workforce.

(d) Infringe on promotional opportunities of any currently employed person.

(2) The department will terminate wage subsidy program or OJT payments to an employer if the employer's worksite or operation becomes involved in a strike, lockout, or bona fide labor dispute.

(3) When a wage subsidy program or OJT agreement has been terminated and payment to the employer discontinued due to displacement of a regular employee, the WorkFirst participant's continued employment with that employer is at the sole discretion of the person and the employer.

(4) A regular employee (or the employee's representative) of an employer which has hired a WorkFirst participant into a subsidized or unpaid work activity who believes the participant's work activity violates any of the provisions under this section has the right to:

(a) A grievance procedure under WAC 388-200-1100; and

(b) A fair hearing under chapter 388-08 WAC.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1800, filed 10/1/97, effective 11/1/97.]

WAC 388-310-1900 WorkFirst—Services for American Indian tribal members and other American Indians.

(1) The department will refer American Indian TANF applicants and recipients to the person's tribe, according to populations and service area(s) specified by a tribal government for comparable WorkFirst services when:

(a) The tribal government operates a federally-approved Tribal TANF program; and

(b) The person is included in the population and service area identified by the tribal government in the plan.

(2) All other American Indian TANF recipients have equitable access to WorkFirst program components and services under this chapter.

[Statutory Authority: RCW 74.08.090 and 74.04.050. 97-20-129, § 388-310-1900, filed 10/1/97, effective 11/1/97.]

Chapter 388-320 WAC

PUBLIC RECORDS DISCLOSURE—ADMINISTRATIVE PROCEDURES

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-320-020	Definitions. [Statutory Authority: RCW 34.05.220 and 42.17.250. 90-17-002 (Order 3048), § 388-320-020, filed 8/2/90, effective 9/2/90. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-020, filed 2/19/81; Order 899, § 388-320-020, filed 1/25/74.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-035	Programs operated by department. [Order 899, § 388-320-035, filed 1/25/74.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-040	Operations and procedure—Organization. [Order 899, § 388-320-040, filed 1/25/74.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-045	Operations and procedure—Office of secretary. [Order 899, § 388-320-045, filed 1/25/74.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-050	Operations and procedure—Program divisions. [Order 899, § 388-320-050, filed 1/25/74.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-055	Operations and procedure—Program division responsibilities. [Order 899, § 388-320-055, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-060	Operations and procedure—Program division operation. [Order 899, § 388-320-060, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-070	Operations and procedure—Administrative divisions. [Order 899, § 388-320-070, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-080	Operations and procedure—Other organizational units. [Order 899, § 388-320-080, filed 1/25/74.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-090	Operations and procedure—Rules adoption and publication. [Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-090, filed 2/19/81; Order 899, § 388-320-090, filed 1/25/74.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-092	Statements of policy. [Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-092, filed 2/19/81; Order 899, § 388-320-092, filed 1/25/74.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-093	Statements of policy—Practice manuals. [Order 899, § 388-320-093, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-094	Statements of policy—State plans. [Order 899, § 388-320-094, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-095	Statements of policy—Other. [Order 899, § 388-320-095, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-120	Office hours. [Order 899, § 388-320-120, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-150	Exemptions. [Order 899, § 388-320-150, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81.

	Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-155	Denial of request. [Order 899, § 388-320-155, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-160	Review of denial. [Order 899, § 388-320-160, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-180	Records index. [Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-180, filed 2/19/81; Order 899, § 388-320-180, filed 1/25/74.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-184	Interpretive and policy statements. [Statutory Authority: RCW 34.05.220 and 42.17.250. 90-17-002 (Order 3048), § 388-320-184, filed 8/2/90, effective 9/2/90.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-185	Final adjudicative order index. [Statutory Authority: RCW 34.05.220 (1)(a). 90-13-054 (Order 3024), § 388-320-185, filed 6/15/90, effective 7/1/90.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-190	Communications and submissions relating to public records. [Order 899, § 388-320-190, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-200	Adoption of form. [Order 899, § 388-320-200, filed 1/25/74.] Repealed by 81-06-001 (Order 1609), filed 2/19/81. Statutory Authority: RCW 42.17.250 through 42.17.340.
388-320-230	Visitation rights of parents. [Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-230, filed 2/19/81.] Repealed by 91-24-047 (Order 3300), filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW.
388-320-340	Delegation of authority by secretary. [Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-340, filed 2/5/90, effective 3/1/90.] Repealed by 98-11-034, filed 5/14/98, effective 6/14/98. Statutory Authority: RCW 34.05.220 and 74.08.090.
388-320-400	Petition for rule making—Form, content, and filing. [Statutory Authority: RCW 34.05.220, 42.17.340 and chapters 17.250 and 17.260 RCW. 93-24-057 (Order 3673), § 388-320-400, filed 11/24/93, effective 12/25/93. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-400, filed 2/5/90, effective 3/1/90.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
388-320-410	Petition for rule making—Consideration and disposition. [Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-410, filed 2/5/90, effective 3/1/90.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
388-320-470	Subscription to adjudicative orders involving nursing homes. [Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-470, filed 11/27/91, effective 12/28/91.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.
388-320-500	Updating mailing lists. [Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-500, filed 2/5/90, effective 3/1/90.] Repealed by 98-01-125, filed 12/18/97, effective 1/18/98. Statutory Authority: RCW 34.05.210, 74.08.090 and 1997 c 409 § 209.

WAC 388-320-010 Purpose. The purpose of this chapter is to ensure compliance by the department of social and

health services with RCW 42.17.250 through 42.17.340, 34.05.220 through 34.05.240, and 34.05.330.

[Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-010, filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-010, filed 2/19/81; Order 899, § 388-320-010, filed 1/25/74.]

WAC 388-320-030 Establishment of department. (1) The department of social and health services was created by chapter 43.20A RCW.

(2) The department was established to integrate and coordinate most of those activities of the state of Washington which involve provision of care for individuals who, because of economic, social, or health conditions, require financial assistance, institutional care, or rehabilitative or other social or health services. Programs the department administers include:

- (a) Aging and adult services;
- (b) Alcohol and substance abuse;
- (c) Children and family services;
- (d) Deaf and hard of hearing;
- (e) Developmental disabilities;
- (f) Income assistance;
- (g) Juvenile rehabilitation;
- (h) Medical assistance;
- (i) Mental health;
- (j) Refugee assistance; and
- (k) Vocational rehabilitation.

(3) The department's basic organizational structure is built around major functions. Responsibility for program development is assigned to staff in state administrative offices located in Olympia. Responsibility for program operation is assigned to staff in regional and local units located throughout the state. An organization chart is available upon request from Media Relations, PO Box 45110, Olympia WA 98504.

[Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-030, filed 11/27/91, effective 12/28/91; Order 899, § 388-320-030, filed 1/25/74.]

WAC 388-320-100 Public records available. (1) All public records of the department are available for disclosure except as otherwise provided by law.

(2) The department shall respond promptly to requests for disclosure. Within five business days of receiving a public record request, the department shall respond by:

- (a) Providing the record;
- (b) Acknowledging that the department has received the request and providing a reasonable estimate of the time the department will require to respond to the request; or
- (c) Denying the public record request.

(3) Additional time for the department to respond to a request may be based upon the need to:

- (a) Clarify the intent of the request;
- (b) Locate and assemble the information requested;
- (c) Notify third persons or agencies affected by the request; or
- (d) Determine whether any of the information requested is exempt and that a denial should be made as to all or part of the request.

(4) In acknowledging receipt of a public record request that is unclear, the department may ask the requestor to clarify what information the requestor is seeking. If the requestor fails to clarify the request, the department need not respond to it.

(5)(a) If the department does not respond in writing within five working days of receipt of the request for disclosure, the person seeking disclosure shall be entitled to:

- (i) Consider the request denied; and
- (ii) Petition the public records officer under WAC 388-320-210.

(b) If the department responds within five working days acknowledging receipt of the request and providing an estimate of the time required to respond to the request, and the requestor feels the amount of time stated is not reasonable, the person seeking disclosure shall be entitled to:

- (i) Consider the request denied; and
- (ii) Petition the public records officer under WAC 388-320-210.

[Statutory Authority: RCW 74.08.090, 92-20-005 (Order 3456), § 388-320-100, filed 9/23/92, effective 10/24/92. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-100, filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-100, filed 2/19/81; Order 899, § 388-320-100, filed 1/25/74.]

WAC 388-320-110 Public records officer. The department shall designate a public records officer, located in the state administrative office, who shall be responsible for implementing the department's rules regarding disclosure of public records, coordination of staff in this regard, and generally insuring compliance by the staff with public records disclosure requirements.

[Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-110, filed 2/19/81; Order 899, § 388-320-110, filed 1/25/74.]

WAC 388-320-115 Disclosure coordinator. The head of each department administrative unit—for example, each CSO or institution—or the department designee shall be the disclosure coordinator for that unit. The coordinator shall, upon request, assist the public or department staff in disclosure matters in that unit.

[Statutory Authority: RCW 74.08.090 and 42.17.260. 94-16-047 (Order 3765), § 388-320-115, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-115, filed 2/19/81; Order 899, § 388-320-115, filed 1/25/74.]

WAC 388-320-130 Request for disclosure of a public record. (1) A request for disclosure of a public record may be oral or written. A request need merely identify with reasonable certainty the record sought to be disclosed.

(2) A request for disclosure shall be made during customary business hours and may be made at any office of the department. A request for research purposes should be made at the human research section (mailing address: in care of the Office of the Secretary, P.O. Box 45010, Olympia WA 98504).

(3) When the law makes a record disclosable to a specific person, a requestor may be required to provide personal identification.

(1999 Ed.)

[Statutory Authority: RCW 74.08.090 and 42.17.260. 94-16-047 (Order 3765), § 388-320-130, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-130, filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-130, filed 2/19/81; Order 899, § 388-320-130, filed 1/25/74.]

WAC 388-320-132 Preserving requested records. If a public record request is made at a time when such record exists but is scheduled for destruction in the near future, the department shall retain possession of the record, and may not destroy or erase the record until the request is resolved.

[Statutory Authority: RCW 74.08.090, 92-20-005 (Order 3456), § 388-320-132, filed 9/23/92, effective 10/24/92.]

WAC 388-320-133 Approval or denial of request.

(1)(a) A request for a record which does not contain exempt information shall be granted and the record disclosed.

(b) A request for a record which contains information that is exempt shall be granted in part when the exempt information can be deleted so release of the remainder does not violate privacy or vital government interest. When a record is released with exempt information deleted, notations which protect privacy and vital government interests should be made so the nature of the deleted information is made known.

(c) A request for a record which contains information that is exempt shall be denied when the exempt information can not be deleted and the remainder released without violating privacy or vital government interest.

(2) A request for a list of individuals requested for commercial purposes shall be denied except as disclosure is authorized under RCW 42.17.260(6).

(3) A denial of a request for disclosure shall be accompanied by a written statement of the specific exemption authorizing the withholding of the record, or part of the record, and a brief explanation of how the exemption applies to the record withheld.

[Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-133, filed 11/27/91, effective 12/28/91.]

WAC 388-320-135 Disclosure to client's representative. (1) When a representative who is not a legislator or attorney requests a client's record, the request must be accompanied by a written release signed by the client. A written release must include:

(a) The identity of the person(s) or organization(s) to whom disclosure is to be made;

(b) An identification of the record, or portion thereof, to be disclosed;

(c) A statement of when the authorization for disclosure expires.

(2) When a representative who is a legislator or attorney requests a client's record, no written release signed by the client is required.

(3) Disclosure of information to a representative shall be made to the same extent as to the client.

(4) The legal guardian of a client has any and all rights accorded to a client by this section.

[Statutory Authority: RCW 74.08.090 and 42.17.260. 94-16-047 (Order 3765), § 388-320-135, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-135, filed 2/19/81.]

WAC 388-320-140 Fees—Inspection and copying. (1)

The department shall not charge a fee for:

- (a) The inspection of public records; or
- (b) Locating public records and making them available for copying.

(2) The department shall collect the following fees to reimburse itself for costs incident to providing copies of public records:

- (a) The actual cost of printing manuals and manual revisions;
- (b) The actual cost of copying blueprints and like materials involving an extraordinary expense;
- (c) Fifteen cents per page for black and white photocopies; and
- (d) The cost of postage if any.

(3) When the department is a party in an administrative hearing, the department shall authorize free copying of records from a department file when the records are demonstrated to be relevant and the client is indigent.

(4) Nothing contained in this section shall preclude the department from agreeing to exchange or provide copies of manuals or other public records with other government agencies when doing so is in the best interest of the department.

(5) The secretary of the department, the secretary's designee, and disclosure coordinators are authorized to waive any of the foregoing costs. Factors considered in deciding whether to waive costs include: Providing the copy will facilitate administering the program and/or the expense of processing the payment exceeds the copying and postage cost.

[Statutory Authority: RCW 74.08.090 and 42.17.300. 96-18-092, § 388-320-140, filed 9/4/96, effective 10/5/96. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-140, filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-140, filed 2/19/81; Order 899, § 388-320-140, filed 1/25/74.]

WAC 388-320-170 Protection of public records. Public records shall be disclosed only in the presence of a public disclosure coordinator or his/her designee, who shall withdraw the records if the person requesting disclosure acts in a manner which will damage or substantially disorganize the records or interfere excessively with other essential functions of the department. This section shall not be construed to prevent the department from accommodating a client by use of the mails in the disclosure process.

[Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-170, filed 2/19/81; Order 899, § 388-320-170, filed 1/25/74.]

WAC 388-320-205 Disclosure procedure. (1) The public disclosure coordinator shall review file materials prior to disclosure.

(2) If the file does not contain materials exempt from disclosure, the public disclosure coordinator shall ensure full disclosure.

(3) If the file does contain materials exempt from disclosure, the public disclosure coordinator shall deny disclosure of those exempt portions of the file, and shall, at the time of the denial, in writing, clearly specify the reasons for the denial of disclosure, including a statement of the specific exemptions or reasons authorizing the withholding of the record and a brief explanation of how the exemption or reason applies. The remaining, nonexempt materials shall be fully disclosed.

[Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-205, filed 2/19/81.]

WAC 388-320-210 Remedy for review of denial of disclosure. (1) If the person requesting disclosure disagrees with the decision of a public disclosure coordinator denying disclosure of a public record, this person may at any time petition the department's public records officer for review of the decision denying disclosure. The form used by the public disclosure coordinator to deny disclosure of a public record shall clearly indicate this right of review.

(2) The public records officer shall review decisions denying disclosure in the most prompt fashion possible, and such review shall be deemed completed at the end of the second business day following receipt by the department of the petition for review. This shall constitute final agency action for the purposes of judicial review, pursuant to RCW 42.17.320.

[Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-210, filed 2/19/81.]

WAC 388-320-220 Exemptions to public records disclosure. Nondisclosable department records exempted by law include:

(1) Personal information in any file maintained for clients of public institutions or welfare recipients, to the extent required by RCW 42.17.310 (1)(a);

(2) Information regarding applicants and recipients of public assistance to the extent required by RCW 74.04.060 and/or 42.17.310 (1)(a);

(3) Vocational rehabilitation records to the extent required by 34 C.F.R. 361.49;

(4) Juvenile justice or juvenile care records to the extent required by chapter 13.50 RCW;

(5) Alcohol and drug abuse patient records to the extent required by 42 C.F.R. chapter 1 part II or other federal law and regulations;

(6) Records concerning applicants or recipients of support enforcement activities to the extent required by 45 C.F.R. 302.18 or RCW 26.23.120;

(7) Office of support enforcement information regarding location of parents to the extent required by RCW 74.20.280;

(8) Adoption and voluntary termination of parent-child relationship records to the extent required by chapter 26.32 RCW and financial information received from adoptive parents to the extent required by RCW 74.13.121;

(9) Mental illness and inebriacy records to the extent required by RCW 71.05.390;

(10) Records of patients and inmates of state institutions to the extent required by RCW 72.01.290;

(11) Nursing home records to the extent required by RCW 18.51.190, 70.124.010, and 74.46.820;

(12) Records maintained by rape crisis centers to the extent required by RCW 70.125.065;

(13) Competitive contract procurement instruments, such as a request for proposals or an invitation for bids, prior to the release to potential bidders; proposals and bids received in response to competitive contract procurement instruments until either the public opening of bids or, for proposals, the contractor and the department have signed the contract, under RCW 43.20A.050;

(14) Personal information in files maintained for an employee or volunteers of the department to the extent required by RCW 42.17.310 (1)(b) and (u);

(15) Specific intelligence information and specific investigative records compiled by investigative, law enforcement, and penology agencies, and state agencies vested with the responsibility to discipline members of any profession, the nondisclosure of which is essential to effective law enforcement or for the protection of any person's right to privacy under RCW 42.17.310 (1)(d). Under the rules set forth in chapter 388-08 WAC, administrative law and review judges may make determinations in the following program areas only: Public assistance and/or food stamp programs as to whether the circumstances of a particular case, when weighing the public interest in protecting the flow of information against the individual's right to prepare the individual's defense, necessitates nondisclosure of particular intelligence or investigative information. Nothing in this regulation shall be deemed to deny adequate opportunity to the appellant or his or her representative, to examine any intelligence or investigative information to be used by the agency at the hearing. As used in these regulations, intelligence and investigative information includes the following:

(a) Allegations or complaints of suspected criminal activity;

(b) Identification of informants, complainants, any person whose physical safety or property may be endangered by such disclosure, and potential witnesses regarding alleged criminal activity;

(c) Identification of and reports concerning criminal suspects other than the person who is the subject of the fair hearing;

(d) Assessments, reports, notes or voice recordings of law enforcement officials or officials of a criminal justice agency, as defined in RCW 10.97.030, concerning the person who is the subject of the fair hearing, informants or potential witnesses; and

(e) Criminal history information relating to persons or organizations other than the person or persons who are the subject of the fair hearing.

(16) Information revealing the identity of persons who are witnesses to or victims of crime or who file complaints with investigative, law enforcement, or penology agencies, other than the public disclosure commission, if disclosure would endanger any person's life, physical safety, or property. If at the time a complaint is filed the complainant, victim, or witness indicates a desire for disclosure or nondisclosure, such desire shall govern pursuant to RCW 42.17.310 (1)(e);

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(17) Preliminary drafts, notes, recommendations, and intra-agency memorandums in which opinions are expressed or policies formulated or recommended, except that a specific record shall not be exempt when publicly cited by the department in connection with any action under RCW 42.17.310 (1)(i);

(18) Records relevant to a controversy to which the department is a party but which records would not be available to another party under the rules of pretrial discovery for causes pending in the superior courts under RCW 42.17.310 (1)(j); and

(19) Information as described under RCW 42.17.320 (1)(cc) that identifies a person who, while an agency employee:

(a) Seeks advice, under an informal process established by the employing agency, in order to ascertain such person's rights in connection with a possible unfair practice under chapter 49.60 RCW against the person; and

(b) Requests such person's identity or any identifying information not be disclosed.

[Statutory Authority: RCW 74.08.090 and 42.17.260, 94-16-047 (Order 3765), § 388-320-220, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 74.08.090, 92-20-005 (Order 3456), § 388-320-220, filed 9/23/92, effective 10/24/92. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-220, filed 11/27/91, effective 12/28/91. Statutory Authority: RCW 34.04.020. 83-03-021 (Order 1938), § 388-320-220, filed 1/13/83. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-220, filed 2/19/81.]

WAC 388-320-225 Qualifications on nondisclosure.

(1) To the extent that nondisclosable information can be deleted from the specific records sought, the remainder of the records shall be disclosable.

(2) No exemptions shall be construed to require nondisclosure of statistical information not descriptive of identifiable persons, as required by RCW 42.17.310(2).

(3) Inspection and copying of any specific records otherwise nondisclosable is permissible pursuant to an order of the superior court enforcing a subpoena in accordance with the provisions of RCW 42.17.310(3), or an order of the office of hearings enforcing a subpoena.

(4) Upon written request of a person who has been properly identified as an officer of the law with a felony arrest warrant or a properly identified United States immigration official with a warrant for an illegal alien the department shall disclose to such officer or official the current address and location of the person described in the warrant, as required by RCW 74.04.062.

(5) The department shall furnish a federal, state, or local law enforcement officer, upon the request of the officer, with the current address of any recipient of temporary assistance for needy families if the officer furnishes the agency with the name of the recipient and notifies the agency that:

(a) The recipient:

(i) Is fleeing prosecution, or custody or confinement after conviction;

(ii) Is a fugitive felon or probation or parole violator as described in WAC 388-215-1550; or

(iii) Has information that is necessary for the officer to conduct the official duties of the officer; and

(b) The location or apprehension of the recipient is within such official duties.

(6) Any person may inquire of the department whether a named individual is a recipient of welfare assistance in accordance with RCW 74.04.060.

(7) Any records of the department may be made accessible for research purposes provided that the research complies with the guidelines published by the department in response to 45 C.F.R. 46 or other applicable state and federal law.

[Statutory Authority: RCW 74.08.090, 74.04.050, 70.04.055 and Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, § 103). 97-07-008, § 388-320-225, filed 3/10/97, effective 4/10/97. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-225, filed 2/19/81.]

WAC 388-320-235 Disclosure for program purposes.

(1) For purposes directly connected with the administration of department programs, information shall be disclosed between different offices of the department, unless prohibited by 45 C.F.R. 205.50 or other law.

(2) For purposes directly connected with the administration of department programs, information may be disclosed by the department to outside agencies, unless disclosure is prohibited by law.

(3) Outside agencies receiving information pursuant to (2) of this section shall be thereby subject to the same standards of disclosure as are required of the department.

[Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-235, filed 2/19/81.]

WAC 388-320-240 Disclosure for other than program purposes. To the extent not otherwise prohibited or authorized by law, a request to disclose a client's record from an agency outside the department seeking disclosure for a purpose other than the administration of the department's program, will be honored only if the client's authorization is included with the request.

[Statutory Authority: RCW 74.08.090 and 42.17.260. 94-16-047 (Order 3765), § 388-320-240, filed 7/27/94, effective 8/27/94. Statutory Authority: RCW 42.17.250 through 42.17.340. 81-06-001 (Order 1609), § 388-320-240, filed 2/19/81.]

WAC 388-320-350 Declaratory orders—Forms, content, and filing. A petition for a declaratory order shall generally adhere to the following form:

(1) At the top of the page shall appear the wording "Before the state department of social and health services." On the left side of page below the foregoing the following caption shall be set out: "In the matter of the petition of (name of petitioning party) for a declaratory order." Opposite the foregoing caption shall appear the word "petition."

(2) The body of the petition shall be set out in numbered paragraphs. The first paragraph shall state the name and address of the petitioning party. The second paragraph shall state all rules or statutes that may be brought into issue by the petition. Succeeding paragraphs shall set out the state of facts relied upon in form similar to that applicable to complaints in civil actions before the superior courts of this state. The concluding paragraphs shall contain the prayer of the petitioner. The petition shall be subscribed and verified in the manner

prescribed for verification of complaints in the superior courts of this state.

(3) The original and two legible copies shall be filed with the Office of Vendor Services, MS 45811, Second Floor East, Office Building 2, Fourteenth and Jefferson, Olympia, WA 98504. Petitions shall be on white paper, 8 1/2" x 11" in size.

[Statutory Authority: RCW 34.05.220, 42.17.340 and chapters 17.250 and 17.260 RCW. 93-24-057 (Order 3673), § 388-320-350, filed 11/24/93, effective 12/25/93. Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-350, filed 2/5/90, effective 3/1/90.]

WAC 388-320-360 Declaratory orders—Procedural rights of persons in relation to petition. If a petition for a declaratory order is set for specified proceedings under RCW 34.05.240 (5)(b), the department shall give not less than seven days advance written notice of the proceedings to the petitioner and all persons described under RCW 34.05.240(3). The notice shall contain the time, date, place, and nature of the proceedings and shall describe how interested persons may participate in the proceeding.

[Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-360, filed 2/5/90, effective 3/1/90.]

WAC 388-320-370 Declaratory orders—Disposition of petition. A declaratory order entered by the department or a decision declining to enter a declaratory order shall be in writing and shall be served upon the petitioner and all other persons described under RCW 34.05.240(3).

[Statutory Authority: RCW 34.05.220 (1)(a). 90-04-076 (Order 2999), § 388-320-370, filed 2/5/90, effective 3/1/90.]

WAC 388-320-450 Interpretive and policy statements roster and index. (1) Legal authority for this rule is RCW 34.05.220 and 42.17.260 (4)(d) and (e).

(2) The department's index of interpretive and policy statements is administered by the office of vendor services. Statements in existence July 1, 1990 were made part of the index and new statements are added to the index upon issuance. The index is revised approximately every two years.

(3) The index is available for public inspection at the Office of Vendor Services located in Office Building No. 2, Olympia WA.

(4) A person wishing to inspect or receive copies of interpretive and policy statements issued by the department shall submit a written request to: Office of Vendor Services, PO Box 45811, Olympia WA 98504-5811.

[Statutory Authority: RCW 34.05.220, 42.17.340 and chapters 17.250 and 17.260 RCW. 93-24-057 (Order 3673), § 388-320-450, filed 11/24/93, effective 12/25/93. Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-450, filed 11/27/91, effective 12/28/91.]

WAC 388-320-460 Final adjudicative and declaratory order index. (1) Legal authority for this rule is RCW 42.17.260 (4)(b) and (c). Each state agency is required to, by rule, establish and implement a system of indexing for the identification and location of final adjudicative orders and declaratory orders that contain an analysis or decision of substantial importance to the agency, in carrying out its duties. The requirement applies to orders entered after June 30, 1990.

(2) The department's adjudicative and declaratory order indexing system is administered by the office of appeals.

(3) The system of indexing is as follows:

(a) Separate indices may be established by program category, including but not limited to benefits, (such as public assistance and food stamps); child support; and license, rate, and similar programs;

(b) Staff of the office of appeals select the orders to be indexed. Review final adjudicative and declaratory orders in all programs are evaluated and those orders which have substantial importance are selected for inclusion in the index;

(c) Any person may nominate a final adjudicative order or declaratory order to be evaluated for indexing by writing the Office of Appeals, PO Box 2465, Olympia WA 98504-2465 and attaching a copy of the nominated order;

(d) Selected orders are indexed by a phrase describing the issue or holding and by a citation to the law involved; and

(e) The index contains a copy or a synopsis of the order.

(4) The index is available for public inspection at the Office of Appeals located in Office Building No. 2, Olympia Washington.

(5) Requests to be on the mailing list of indexed orders shall be made to: Office of Appeals, PO Box 2465, Olympia WA 98504-2465.

[Statutory Authority: RCW 42.17.240, 34.05.220 and chapters 17.250 and 17.260 RCW. 91-24-047 (Order 3300), § 388-320-460, filed 11/27/91, effective 12/28/91.]

Chapter 388-330 WAC BACKGROUND INQUIRIES

WAC

388-330-010	Purpose and authority.
388-330-020	Scope.
388-330-030	Application of inquiry findings.
388-330-035	Appeal of disqualification.
388-330-040	Inquiry form to be submitted—Time requirements.
388-330-050	Release of information.
388-330-060	Sanctions for noncompliance.

WAC 388-330-010 Purpose and authority. This chapter establishes policy within the department of social and health services for conducting background inquiries and checks of Washington state child abuse information files on those licensed or authorized by the department to care for children or developmentally disabled persons and those employed by or associated with a licensed agency. Such inquiries are required under RCW 74.15.030.

[Statutory Authority: RCW 74.15.030. 96-10-043 (Order 3974), § 388-330-010, filed 4/26/96, effective 5/27/96; 93-15-040 (Order 3534), § 388-330-010, filed 7/13/93, effective 8/13/93; 89-07-096 (Order 2777), § 388-330-010, filed 3/22/89.]

WAC 388-330-020 Scope. (1) Background inquiries. The department's background inquiries:

(a) Shall include, but not be limited to review of:

(i) Records of criminal convictions and pending criminal charges as listed by the Washington state patrol (WSP) per chapters 10.97 and 43.43 RCW;

(ii) Washington state patrol file of a person found to be a child abuser in a civil adjudication or a disciplinary board final decision; and

(1999 Ed.)

(iii) Child protective service and case file information in the case and management information system and division of children and family services (DCFS) records.

(b) May include a review of law enforcement records of convictions and pending charges in other states or locations when the need for further information is indicated by:

(i) A person's prior residences;

(ii) Reports from credible community sources; or

(iii) An identification number indicating the subject has a record on file with the Federal Bureau of Investigation.

(2) Affected persons. Persons subject to background inquiries include:

(a) All persons licensed to care for children or disabled persons under:

(i) Chapter 74.15 RCW; or

(ii) Contract with the department to provide that care.

(b) All staff, employed by licensed or authorized providers, involved in the direct care or supervision of children and developmentally disabled persons;

(c) Any volunteer or other person having regular, unsupervised access to children or developmentally disabled persons in facilities, homes, or operations licensed or authorized by the department to provide care under chapter 74.15 RCW.

(3) Persons not affected. This chapter does not apply to schools, hospitals, or other facilities where the primary focus is not custodial and where the provider is not acting in place of the parent.

(4) This chapter does not apply to persons being considered for employment or volunteer activities with the department of social and health services. Background check requirements applicable to department employees and volunteers are set forth in MSR 326-26-140 and 2SSB 5063, chapter 486, Laws of 1987, respectively.

[Statutory Authority: RCW 74.15.030. 93-15-040 (Order 3534), § 388-330-020, filed 7/13/93, effective 8/13/93; 89-07-096 (Order 2777), § 388-330-020, filed 3/22/89.]

WAC 388-330-030 Application of inquiry findings.

(1) For the purposes of conducting criminal history portions of background inquiries under RCW 74.15.030, the department shall only consider a person's convictions and pending charges. The department shall not solicit or use as the sole basis for disqualification information about:

(a) Arrests not resulting in charges; and

(b) Dismissed charges.

(2) The department shall maintain a listing of offenses which, because of their seriousness, shall disqualify prospective care providers from being licensed or otherwise authorized to provide care to children or developmentally disabled persons. The following offenses or their equivalents in jurisdictions outside of the state of Washington shall constitute that list:

(a) Aggravated murder;

(b) Murder in the first degree;

(c) Murder in the second degree;

(d) Manslaughter in the first degree;

(e) Manslaughter in the second degree;

(f) Simple assault, if the assault involves physical harm to another person;

(g) Assault in the first degree;

- (h) Assault in the second degree;
- (i) Assault in the third degree;
- (j) Custodial assault;
- (k) Vehicular homicide;
- (l) Criminal mistreatment in the first degree;
- (m) Criminal mistreatment in the second degree;
- (n) Reckless endangerment;
- (o) Kidnapping in the first degree;
- (p) Kidnapping in the second degree;
- (q) Unlawful imprisonment;
- (r) Rape in the first degree;
- (s) Rape in the second degree;
- (t) Rape in the third degree;
- (u) First degree rape of a child;
- (v) Second degree rape of a child;
- (w) Third degree rape of a child;
- (x) Child molestation in the first degree;
- (y) Child molestation in the second degree;
- (z) Child molestation in the third degree;
- (aa) Sexual misconduct with a minor in the first degree;
- (bb) Sexual misconduct with a minor in the second degree;
- (cc) Indecent liberties;
- (dd) Felony indecent exposure;
- (ee) Arson in the first degree;
- (ff) Arson in the second degree;
- (gg) Burglary in the first degree;
- (hh) Extortion in the first degree;
- (ii) Extortion in the second degree;
- (jj) Robbery in the first degree;
- (kk) Robbery in the second degree;
- (ll) Incest in the first degree;
- (mm) Incest in the second degree;
- (nn) Promoting prostitution in the first degree;
- (oo) Promoting prostitution in the second degree;
- (pp) Sexual exploitation of a minor;
- (qq) Communication with a minor for immoral purposes;
- (rr) Child selling - child buying;
- (ss) Public indecency, if toward a person under fourteen years of age;
- (tt) Prostitution;
- (uu) Dealing in depictions of a minor engaged in sexually explicit conduct;
- (vv) Sending or bringing into the state depictions of a minor engaged in sexually explicit conduct;
- (ww) Possession of depictions of a minor engaged in sexually explicit conduct;
- (xx) Patronizing a juvenile prostitute;
- (yy) Family abandonment;
- (zz) Child abandonment;
- (aaa) Unlawfully manufacturing, delivering, or possessing, with intent to deliver, a controlled substance;
- (bbb) Promoting a suicide attempt;
- (ccc) Malicious harassment;
- (ddd) Promoting pornography;
- (eee) Coercion;
- (fff) Child abuse or neglect as defined under RCW 26.44.020;
- (ggg) Violation of child abuse restraining order; and
- (hhh) First or second degree custodial interference.

(3) Whenever a criminal history inquiry reveals a prospective care provider has been charged with or convicted of an offense or is in the WSP file as a person found to be a child abuser in a civil adjudication or disciplinary board final decision, the department shall take action as follows:

(a) If it is confirmed the subject's name appears on the aforementioned WSP file of child abusers, that person shall not be licensed, employed by licensees or contractors, serve in a volunteer capacity for licensees or contractors, or otherwise be authorized by the department to provide care;

(b) If the inquiry reveals charges are pending against the subject for any of the offenses listed in subsection (2) of this section, or their equivalents in other jurisdictions, the department shall withhold licensure or authorization to provide care until dismissal or acquittal occurs. Pending charges for other offenses may be grounds for withholding licensure or authorization to provide care. If the inquiry reveals pending charges are more than one year old, the department shall contact the charging law enforcement agency to determine the disposition or status of the charge;

(c) If the inquiry reveals the subject has been convicted of any of the offenses listed in subsection (2) of this section or their equivalents in other jurisdictions, the department shall deny licensure or authorization to provide care. The department at its discretion may license a person or authorize a person to provide care despite a conviction under subsection (2) of this section if the person presents to the department a certificate of rehabilitation issued by a superior court under RCW 43.43.830(4). A certificate of rehabilitation shall address the fitness of the person to provide the specific type of care considering the following factors:

(i) The seriousness and circumstances of the illegal act;

(ii) The number of crimes for which the person was convicted;

(iii) The amount of time passed since the illegal act was committed;

(iv) The age of the person at the time of conviction;

(v) Whether the person has entered and successfully completed all appropriate rehabilitative services, including those ordered by a court;

(vi) The behavior of the person since the illegal act was committed;

(vii) Recommendations of persons closely associated with the person;

(viii) The duties the person would perform at the agency, and the vulnerability of the persons under care; and

(ix) Other evidence of rehabilitation.

If the department licenses or approves a person under this subsection, it may place limitations or conditions on the person in the performance of the person's duties at the agency.

(d) If the inquiry reveals the subject has been convicted of an offense not listed in subsection (2) of this section, the department shall consider such information in determining the character, suitability, and competence of the prospective caretaker as required by chapter 74.15 RCW. However, the department shall not use conviction as the sole basis for denial of licensure or authorization to provide care unless the conviction is directly related to the employment, licensure, or authorization being sought. The department shall consider

the recency, seriousness, kind, and number of previous offenses, as well as the vulnerability of the clients to be cared for.

[Statutory Authority: RCW 74.15.030. 93-15-040 (Order 3534), § 388-330-030, filed 7/13/93, effective 8/13/93. Statutory Authority: RCW 74.15.030, chapters 74.15 and 43.43 RCW. 92-08-038, § 388-330-030, filed 3/24/92, effective 4/24/92. Statutory Authority: RCW 74.15.030. 89-07-096 (Order 2777), § 388-330-030, filed 3/22/89.]

WAC 388-330-035 Appeal of disqualification. (1)

Whenever a person in good faith desires employment in an agency licensed under chapter 74.15 RCW, the person, prior to applying for employment, upon request, shall promptly receive from the department an informal meeting on whether the person is disqualified from employment for not meeting the minimum requirements pursuant to chapter 74.15 RCW or rules promulgated thereunder.

(a) Prior to receiving an informal meeting under this subsection, it shall be the responsibility of a person requesting the meeting to demonstrate a good faith desire for employment in an agency licensed under chapter 74.15 RCW. Such demonstration of good faith shall include, but not be limited to, a showing of educational qualifications, employment history information, current employment, and plans for obtaining employment in a licensed agency in the near future. The department's determination regarding whether the person requesting the meeting has demonstrated a good faith desire for employment is final and not subject to a proceeding under chapter 34.05 RCW. The department shall notify such person promptly following the meeting of its determination in writing.

(b) If the department determines, subsequent to an informal meeting under this subsection, that a person is disqualified, the department shall give written notice of the disqualification to the person. The notice shall state what the person is disqualified from doing, the reasons for the disqualification, the applicable law under which the person is disqualified, and their right to an adjudicative proceeding under chapter 34.05 RCW.

(2) If the department during employment or at the time of employment, determines that a person is disqualified from employment with a child care agency for not meeting minimum requirements under chapter 74.15 RCW or rules promulgated thereunder, the department shall give written notice of disqualification to the person. The notice shall state what the person is disqualified from doing, reasons for the disqualification, and the applicable law under which the person is disqualified, and their right to an adjudicative proceeding under chapter 34.05 RCW.

(3) The procedures in RCW 43.20A.205 shall apply whenever the department issues a notice of disqualification to a person under this section. If the disqualified person requests an adjudicative proceeding, the department shall have the burden of proving disqualification by a preponderance of the evidence.

(4) A licensee under chapter 74.15 RCW may not allow a person disqualified under this section to be employed by or associate with the licensee's agency. Disqualification of a person may not be contested by a licensee.

(5) The provisions of this section do not preclude the department from taking any action against a licensee in

accordance with chapter 74.15 RCW or rules promulgated thereunder.

(6) If after a hearing under chapter 34.05 RCW it is determined that the allegations are not supported by a preponderance of the evidence, the department's records shall be supplemented to so state and the person and any employer shall be informed that there is nothing prohibiting the person from being employed by or associated with a licensed child care agency. If an employer is aware that the hearing has occurred, the employer shall additionally be informed that the department failed to prove the allegations at issue in the hearing.

(7) If at a hearing under chapter 34.05 RCW the appellant proves by clear, cogent and convincing evidence that the incident of abuse or neglect on which the notice of disqualification is based did not occur and that the allegation is false, the record shall be supplemented to so state, and the department shall restrict access to all such reports so that the reports will not thereafter be considered by the department in determining whether a person is disqualified.

(8) The department in accordance with WAC 388-330-030 may remove a disqualification based on conviction of a crime.

The department may remove a disqualification based on a reason other than conviction of a crime if the disqualified person demonstrates by clear, cogent, and convincing evidence that the person is sufficiently rehabilitated to warrant public trust and to comply with the requirements of chapter 74.15 RCW, and the rules promulgated thereunder.

[Statutory Authority: RCW 74.15.030. 97-13-002, § 388-330-035, filed 6/4/97, effective 7/5/97; 96-10-043 (Order 3974), § 388-330-035, filed 4/26/96, effective 5/27/96.]

WAC 388-330-040 Inquiry form to be submitted—Time requirements. (1) Applicants for licensure under chapter 74.15 RCW shall complete the background inquiry form at the time of application.

(2) Employees and volunteers of those licensed or otherwise authorized to provide care under chapter 74.15 RCW shall complete and submit the DSHS background inquiry form to the person licensed or authorized to provide care. This shall be done prior to or as soon as possible after being on the premises and having regular unsupervised contact with children or developmentally disabled persons. The employer, licensee, or authorized person shall submit the properly completed form to the appropriate DSHS licensor or authorizing person within seven calendar days of the time the employee or volunteer had regular unsupervised contact.

(3) The department shall not issue a license or otherwise authorize persons to provide care until they have properly completed and submitted the inquiry form and the results are known to the department; except, such care may be authorized if the inquiry form has been submitted. If a child is placed with a relative under RCW 13.34.060 or 13.34.130, and if such relative appears otherwise suitable and competent to provide care and treatment, the criminal history background check required by this section need not be completed before placement, but shall be completed as soon as possible after placement.

[Statutory Authority: RCW 74.15.030. 89-07-096 (Order 2777), § 388-330-040, filed 3/22/89.]

WAC 388-330-050 Release of information. (1) Release of criminal history information.

(a) Unless there is a signed release of information, the department may only share with a provider:

(i) The criminal inquiry information used to disqualify an employee or volunteer of that provider; or

(ii) The fact the subject is listed on the Washington state patrol's child abuse information file if that is the basis for a disqualification.

(b) The department shall not share any other inquiry information with the provider or provider's employees unless the department withheld licensure or care authorization based on that information.

(2) Release of abuse information from department files.

(a) The department shall not share with care providers or prospective providers any abuse information in department files.

(b) Unless there is a release of information signed by the employee, the department may only tell a provider or prospective provider that the results of the department's background inquiry disqualify the employee. Even if the employee has signed a release of information, the department shall not discuss identifying information about the victim of the abuse.

(3) Release of inquiry findings to the subject of inquiry. The department shall provide disqualified care providers with inquiry findings about themselves if the providers:

(a) Make the requests in writing; and

(b) Offer proof of identity.

[Statutory Authority: RCW 74.15.030. 93-15-040 (Order 3534), § 388-330-050, filed 7/13/93, effective 8/13/93; 89-07-096 (Order 2777), § 388-330-050, filed 3/22/89.]

WAC 388-330-060 Sanctions for noncompliance. Any licensee, employer, contractor, or other care provider within the scope of this chapter may be subject to sanctions by the department pursuant to applicable licensing requirements or statutes or contractual agreements for failure to comply with the requirements of this chapter.

[Statutory Authority: RCW 74.15.030. 89-07-096 (Order 2777), § 388-330-060, filed 3/22/89.]

**Chapter 388-400 WAC
PROGRAM SUMMARY**

WAC

388-400-0005	Temporary assistance for needy families—General eligibility requirements.
388-400-0010	State family assistance—Summary of eligibility requirements.
388-400-0015	General assistance for children—Summary of eligibility requirements.
388-400-0020	General assistance for pregnant women—General eligibility requirements.
388-400-0025	General assistance unemployable—General eligibility requirements.
388-400-0030	Refugee cash assistance—Summary of eligibility requirements.
388-400-0035	Refugee medical assistance—Summary of eligibility requirements.
388-400-0040	General eligibility requirements for the federal food assistance program.

388-400-0045 Food assistance program for legal immigrants (FAP)—General eligibility requirements.

WAC 388-400-0005 Temporary assistance for needy families—General eligibility requirements. (1) To be eligible for temporary assistance for needy families (TANF), a child must:

(a) Meet the age requirements under WAC 388-404-0005;

(b) Live in the home of a relative as required under chapter 388-454 WAC;

(c) Be deprived of parental support and care as required under chapter 388-430 WAC; and

(d) Live with a parent who is not ineligible for TANF due to the time limit requirements of WAC 388-484-0005.

(2) To be eligible for TANF, a person must:

(a) Meet the citizenship/alien status requirements of WAC 388-424-0005;

(b) Reside in the state of Washington, or, if a child, live with a parent or other relative who meets the state residency requirements of WAC 388-468-0005;

(c) Be in financial need as specified under chapters 388-450, 388-470 and 388-488 WAC;

(d) Assign any rights to child support and cooperate in establishing paternity and collecting child support as required under chapter 388-422 WAC;

(e) Provide a Social Security number as required under WAC 388-476-0005;

(f) Cooperate in a review of eligibility as required under WAC 388-434-0005;

(g) Cooperate in a quality assurance review as required under WAC 388-464-0005;

(h) Participate in the WorkFirst program as required under chapter 388-310 WAC;

(i) Not be participating in a strike as defined under WAC 388-480-0005;

(j) Report circumstances monthly as required under chapter 388-456 WAC;

(k) Report changes of circumstances as required under chapter 388-418 WAC; and

(l) If a pregnant woman who is not otherwise eligible for TANF; meet the requirements of WAC 388-462-0010.

(3) TANF assistance units for children and caretaker relatives are established according to chapter 388-408 WAC.

(4) The following persons are not eligible for TANF:

(a) Persons convicted of certain felonies and other crimes as specified in chapter 388-442 WAC; and

(b) Persons convicted of unlawful practices in obtaining public assistance as specified in chapter 388-446 WAC.

(5) Unmarried pregnant and parenting teens must meet the living arrangement and school attendance requirements of chapter 388-486 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0010 State family assistance—Summary of eligibility requirements. (1) To be eligible for state family assistance (SFA), a person must:

(a) Meet all temporary assistance for needy families (TANF) eligibility requirements except those for citizenship and alien status; and

(b) Meet the citizenship/residence requirements as specified in WAC 388-424-0015.

(2) An assistance unit is not eligible for SFA if it includes an adult who has received SFA, TANF, or a combination of SFA and TANF for a total of sixty months since August 1, 1997. Months are disregarded as specified under WAC 388-484-0005 when calculating the number of months an adult family member has received SFA or TANF.

(3) Assistance units for families with members who meet SFA and TANF citizenship/alien status requirements will be established under the TANF assistance unit rules in chapter 388-408 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0015 General assistance for children—Summary of eligibility requirements. (1) To be eligible for general assistance for children (GA-H), a child must:

(a) Live with a court-appointed legal guardian or court appointed permanent custodian as required under chapter 388-454 WAC;

(b) Meet the general assistance citizenship/alien status requirements under WAC 388-424-0005(3);

(c) Be in financial need according to temporary assistance for needy families (TANF) income and resource rules in chapters 388-450, 388-470 and 388-488 WAC, except that child support received is considered the child's unearned income; and

(d) Meet all other requirements of a child eligible for TANF except citizenship/alien status and requirements to:

(i) Live with a relative of specified degree; and
(ii) Participate in WorkFirst activities if not in school.

(2) A child is not eligible for GA-H if:

(a) The child is eligible for or receives TANF or Supplemental Security Income (SSI); or

(b) The child or the child's caretaker has refused or failed to cooperate in obtaining TANF or SSI on behalf of the child.

(3) A GA-H assistance unit is established as specified in WAC 388-408-0010.

(4) The child's custodian or payee is the GA-H grant payee.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0020 General assistance for pregnant women—General eligibility requirements. (1) To be eligible for general assistance for pregnant women (GA-S), a woman must:

(a) Meet the requirements of WAC 388-462-0005; and

(b) Meet the general assistance citizenship/alien status requirements under WAC 388-424-0005(3);

(c) Be in financial need according to temporary assistance for needy families (TANF) income and resource rules in chapters 388-450, 388-470 and 388-488 WAC;

(d) Provide a Social Security number as required under WAC 388-476-0005; and

(e) Reside in the state of Washington as required under WAC 388-468-0005.

(2) A woman is not eligible for GA-S if she:

(a) Is eligible for or her needs are being met by the Supplemental Security Income (SSI) program TANF or state family assistance (SFA);

(b) Is under sanction for failing to comply with SSI requirements;

(c) Fails or refuses to cooperate without good cause in obtaining SSI; or

(d) Fails or refuses to cooperate in obtaining TANF or SFA. This includes disqualifications for:

(i) Convictions for misrepresenting residence to obtain assistance in two or more state as specified under chapter 388-446 WAC;

(ii) Convictions for drug-related felonies and failing to complete drug treatment as specified under chapter 388-442 WAC;

(iii) Failing to report a child's absence within five days of becoming reasonably certain the absence will exceed ninety days as specified in chapter 388-418 WAC; or

(iv) Failing to meet school attendance requirements for unmarried teen parents as specified under chapter 388-486 WAC.

(3) The assistance unit for a woman applying for or receiving GA-S will be established according to WAC 388-408-0010.

(4) Unmarried pregnant or parenting minors who are not emancipated under a court decree must meet the living arrangement requirements of WAC 388-486-0005.

(5) A pregnant woman in an institution may be eligible for GA-S as specified under WAC 388-230-0080.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0025 General assistance unemployed—General eligibility requirements. (1) To be eligible for general assistance - unemployable (GA-U), a person must:

(a) Be incapacitated as required under WAC 388-235-5000 through 388-235-6000;

(b) Meet the age requirement of WAC 388-404-0010;

(c) Be in financial need according to GA-U income and temporary assistance for needy families (TANF) resource rules in chapters 388-450, 388-470 and 388-488 WAC;

(d) Meet the general assistance citizenship/alien status requirements under WAC 388-424-0005(3);

(e) Provide a Social Security number as required under WAC 388-476-0005;

(f) Reside in the state of Washington as required under WAC 388-468-0005;

(g) Undergo a treatment and referral assessment as provided under WAC 388-235-7000 through 388-235-7600;

(h) Assign interim assistance as provided under WAC 388-235-9200 and 388-235-9300;

(i) Not be eligible for or receiving benefits from other programs as specified under WAC 388-235-9000.

(2) The assistance unit for a person applying for or receiving GA-U will be established according to WAC 388-408-0010.

(3) A person in an institution may be eligible for GA-U as specified under WAC 388-235-1500.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0030 Refugee cash assistance—Summary of eligibility requirements. (1) To be eligible for refugee cash assistance (RCA), persons must:

(a) Provide the name of the voluntary agency (VOLAG) which resettled them; and

(b) Meet the:

(i) Immigration status requirements of WAC 388-466-0005;

(ii) Work and training requirements of WAC 388-466-0015;

(iii) Income and resource requirements under chapters 388-450 and 388-470 WAC with exceptions as provided under WAC 388-466-0010; and

(iv) Monthly reporting requirements of chapter 388-456 WAC.

(2) Persons are not eligible to receive RCA if they:

(a) Are eligible for temporary assistance for needy families (TANF) or Supplemental Security Income;

(b) Have been denied TANF or have been terminated from TANF due to intentional noncompliance with TANF eligibility requirements; or

(c) Are full-time students in institutions of higher education unless the educational activity is part of a department-approved employability plan.

(3) Refugee families, including families with children who are United States citizens, will be treated as single assistance units according to chapter 388-408 WAC.

(4) Eligibility and benefit levels for RCA assistance units are determined using the TANF payment standards in WAC 388-478-0020.

(5) Persons eligible for RCA are eligible for additional requirements for emergent situations as provided in chapter 388-436 WAC.

(6) A person meeting the requirements of this section is eligible for refugee cash assistance only during the eight-month period beginning in the first month the person entered the United States.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0035 Refugee medical assistance—Summary of eligibility requirements. (1) To be eligible for refugee medical assistance (RMA), persons must:

(a) Provide the name of the voluntary agency (VOLAG) which resettled them; and

(b) Meet the immigration status requirements of WAC 388-466-0005.

(2) Except for a person who is not eligible under subsection (3) of this section, a person is eligible for RMA if the person:

(a) Receives refugee cash assistance (RCA); or

(b) Is eligible for but chooses not to apply for or receive RCA.

(3) Persons are not eligible to receive RMA if they are:

(a) Eligible for Medicaid;

(b) Are not eligible for RCA because they have not met the employment and training requirements of WAC 388-466-0015; or

(c) Are full-time students in institutions of higher education unless the educational activity is part of a department-approved employability plan.

(4) Refugee families, including families with children who are United States citizens, will be treated as single assistance units according to chapter 388-408 WAC.

(5) A person meeting the requirements of this section is eligible for RMA only during the eight-month period beginning in the first month the person entered the United States.

(6) A recipient of RCA and RMA who becomes ineligible for RCA due to an increase in income remains eligible for extended RMA benefits until the end of the eighth month period following entry into the United States.

(7) A person will have his or her eligibility for RMA determined based on the rules for the medically needy program if the person is:

(a) Not eligible for Medicaid; or

(b) Not eligible for RCA because of excess income, unless the person is eligible for extended RMA under subsection (6) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0040 General eligibility requirements for the federal food assistance program. (1) Persons applying for benefits for the federal food assistance program must meet certain eligibility criteria established under the Food Stamp Act of 1977 as amended.

(2) When a person applies for benefits, a decision is made about who must be included in the assistance unit as specified under WAC 388-408-0035.

(3) After the assistance unit is determined, all members must:

(a) Be U.S. citizens or nationals as specified under WAC 388-424-0005(1); or

(b) Be qualified aliens as specified under WAC 388-424-0020;

(c) Be residents of the state of Washington as specified under chapter 388-468 WAC; and

(d) Provide Social Security numbers as specified under chapter 388-476 WAC.

(4) To be eligible, an assistance unit must:

(a) Have income at or below gross and net income standards unless excluded from these standards as specified under WAC 388-478-0060;

(b) Own resources at or below the applicable resource limits as specified in WAC 388-470-0005;

(c) Provide identity as specified under WAC 388-406-0015;

(d) Participate in the food stamp employment and training program (FSE&T) as specified under chapter 388-444 WAC;

(e) Meet the eligibility criteria for strikers as specified in chapter 388-480 WAC;

(f) Return a completed monthly report as required under chapter 388-456 WAC.

(5) Assistance units are allowed deductions from their income as specified under WAC 388-450-0200.

(6) Persons with disabilities may be allowed special consideration as explained in subsection (7) of this section, when the person:

(a) Receives SSI;

(b) Receives disability payments;

(i) Under Titles I, II, XIV, or XVI of the Social Security Act;

(ii) From a local, state or federal government agency that considers the disability as permanent under section 221(i) of the Social Security Act;

(iii) From the Railroad Retirement Act under sections 2(a)(1)(iv) and (v) and meets Title XIX disability elements or is eligible for Medicare.

(c) Receives disability-related medical assistance under Title XIX of the Social Security Act;

(d) Is a veteran and receives disability payments rated at one hundred percent;

(e) Is a spouse of a veteran and:

(i) Is in need of an attendant or permanently housebound; or

(ii) Has a disability as described under section 221(i) of the Social Security Act and entitled to death or pension payments under Title 38 of the USC.

(7) A person with disabilities described in subsection (6) of this section:

(a) Does not have to have income at or below the gross income standard, only the net income standard;

(b) May be entitled to a medical deduction as described under chapter 388-450 WAC; or

(c) Is not required to count the value of a vehicle when the vehicle is needed to transport them as specified under WAC 388-470-0070 and 388-470-0075.

(8) The following persons applying for food assistance are denied benefits:

(a) Students attending an institution of higher education when the student does not meet the eligibility factors as specified under WAC 388-482-0005;

(b) Able-bodied adults without dependents who are no longer eligible under WAC 388-444-0030; and

(c) Assistance units who participate in the food distribution program. This program is available to assistance units living on or near an Indian reservation. The program is administered by tribal organizations approved by the federal Food and Nutrition Service (FNS).

(9) The following persons applying for food assistance are denied benefits but some of their income and all of their resources are considered available to the eligible assistance unit members:

(a) Fugitive felons including probation and parole violators and felons convicted of drug-related felonies as specified under chapter 388-442 WAC;

(b) Persons failing to attest to citizenship or alien status under WAC 388-408-0035(9);

(c) Persons disqualified for:

(i) An intentional program violation as specified under WAC 388-446-0015;

(ii) Failure to provide a Social Security number under chapter 388-476 WAC; or

(iii) Not participating with work requirements as specified under chapter 388-444 WAC; or

(d) Persons who are ineligible aliens under WAC 388-424-0020.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-400-0045 Food assistance program for legal immigrants (FAP)—General eligibility requirements. (1) A legal immigrant meets alien status eligibility for the state-funded food assistance program if the immigrant:

(a) Meets those alien status requirements of the Food Stamp Act of 1977 in effect prior to August 22, 1996;

(b) Is not eligible for federal food stamps solely due to the immigrant provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193, as amended. The immigrant must meet alien status rules under WAC 388-424-0025.

(2) FAP provides the same amount of benefits as the federal food stamp program. Some assistance units may receive a combined benefit of both state and federal food stamps. Food assistance benefit levels are found in WAC 388-478-0060.

(3) FAP follows the same eligibility rules, except for alien status, as the federal food stamp program. The federal food stamp program summary is found in WAC 388-400-0040.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-400-0045, filed 7/31/98, effective 9/1/98.]

Chapter 388-404 WAC AGE REQUIREMENTS

WAC

388-404-0005 Age of child eligible for TANF, SFA and GA-H.

388-404-0010 Age requirement for GA-U and ADATSA.

388-404-0015 Definition of elderly person for food and cash assistance programs.

WAC 388-404-0005 Age of child eligible for TANF, SFA and GA-H. To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA) or general assistance for children (GA-H), a child must be:

(1) Under age eighteen; or

(2) Under age nineteen; and:

(a) Participating full-time in a secondary school program or the equivalent level of vocational or technical training; and

(b) Reasonably expected to complete the program by the end of the month in which the child reaches age nineteen.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-404-0010 Age requirement for GA-U and ADATSA. To be eligible for general assistance - unemployed (GA-U) or the ADATSA program a person must be:

(1) At least eighteen years of age or older; or

(2) For GA-U only, if under eighteen years of age, a member of a married couple:

(a) Residing together, or

- (b) Residing apart solely because a spouse is:
 - (i) On a visit of ninety days or less;
 - (ii) In a public or private institution;
 - (iii) Receiving care in a hospital, long-term care facility, or chemical dependency treatment facility; or
 - (iv) On active duty in the uniformed military services of the United States.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-404-0015 Definition of elderly person for food and cash assistance programs. For food and cash assistance, "elderly person" means a person sixty years of age or older.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-404-0015, filed 7/31/98, effective 9/1/98.]

Chapter 388-406 WAC APPLICATIONS

WAC

388-406-0005	Who may apply.
388-406-0010	Filing an application.
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388-406-0020	Destitute household definition.
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388-406-0030	Requests for additional information.
388-406-0035	Time limits for processing applications.
388-406-0040	Delays in application processing.
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388-406-0050	Completing the application process.
388-406-0055	Date of eligibility for approved applications.
388-406-0060	Denial of applications.
388-406-0065	Reconsideration of denied applications.

WAC 388-406-0005 Who may apply. Any person may file an application for cash, medical or food assistance.

(1) For food assistance, applications may be made by a responsible household member or an authorized representative.

(2) For medical and cash assistance, an application may be made by:

(a) Persons applying on their own behalf or on behalf of their dependents;

(b) A legal guardian or caretaker applying on behalf of a minor or incompetent person; or

(c) Any other person acting on behalf of the applicant when application cannot be made under one of the preceding methods. For cash assistance the person must indicate the reason the applicant is not able to apply on his or her own behalf.

(3) For GA-U and medical programs, a Washington state resident who is temporarily living out of the state may apply through a person or agency acting on the client's behalf.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0405 and 388-504-0410.]

WAC 388-406-0010 Filing an application. (1) A person may file an application by submitting a written request for benefits using a form designated by the department, to the

applicant's local community service office (CSO) in person or by mail.

(a) A person may file an application on the same day that benefits are requested when the request is made in the applicant's local CSO during regular business hours.

(b) A household applying for food, medical and/or cash assistance may do so by submitting a single request for benefits.

(c) For food assistance, a household consisting only of clients applying for or receiving Supplemental Security Income (SSI) may file an application at the local Social Security Administration District Office (SSADO).

(d) Clients who receive SSI or who are otherwise determined eligible for Medicaid by the Social Security Administration will be authorized medical assistance without being required to file a separate application with the department.

(2) The request for benefits form must be as brief as administratively possible and seek information ordinarily known to the applicant, including:

(a) The name and address of the applicant;

(b) The type of assistance requested (i.e., food, medical and/or cash assistance);

(c) For medical and cash assistance:

(i) The applicant's telephone number, if known; and

(ii) The names, birthdates and social security numbers, if known, of all persons for whom assistance is requested; and

(d) For TANF and SFA, the names, birthdates and social security numbers, if known, of:

(i) All children under the age of nineteen who are living in the home and who are siblings of any child for whom assistance is being requested; and

(ii) All parents, if living in the home, of any child for whom assistance is requested.

(e) An application is required for a medically needy program client who requests eligibility beyond the certification period.

(3) To initiate an application, the filed request for benefits form must include:

(a) The name and address of the applicant; and

(b) The signature of the applicant or the applicant's representative.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0405.]

WAC 388-406-0015 Expedited service for food assistance. (1) Households eligible for expedited service will receive food assistance benefits by the end of the fifth calendar day from the date of application. For SSI recipients, this time frame begins on the date the:

(a) Applicant's local CSO receives the application of a noninstitutionalized SSI household; or

(b) Applicant is released from a public institution.

(2) Applicants are eligible for expedited service when the household:

(a) Has liquid resources of one hundred dollars or less and has gross monthly income under one hundred fifty dollars; or

(b) Has combined gross monthly income and liquid resources which are less than the household's current monthly rent and applicable utility allowance; or

(c) When all members are homeless; or

(d) Includes a destitute migrant or seasonal farmworker, as defined in WAC 388-406-0020, whose liquid resources do not exceed one hundred dollars.

(3) A household must provide verification of:

(a) The identity of the applicant; or

(b) The identity of the authorized representative who is applying for the household; and

(c) Other eligibility factors that can be verified within the five day time period specified in subsection (1) of this section.

(4) A household is not limited to the number of times it can receive expedited service if, following the last expedited certification, the household:

(a) Completes the postponed verification requirements; or

(b) Was certified by the regular nonexpedited processing methods.

(5) When a household is eligible for expedited service and an office interview is not required, the household will have:

(a) A telephone interview or home visit; and

(b) Still receive their benefits within the five-day expedited time period.

(6) A household is entitled to an agency conference within two working days from the date of denial for expedited service.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0020 Destitute household definition.

(1) A migrant or seasonal farmworker is considered destitute for the purposes of eligibility for food assistance when:

(a) The household's income for the month of application was received before the date of application and was from a source no longer providing income; or

(b) The household's income for the month of application is from a new source and the household will receive no more than twenty-five dollars during the ten calendar days from the date of application.

(2) A household member changing jobs but continuing to work for the same employer is considered to be receiving income from the same source.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0025 Applicant to provide information needed to determine eligibility. The applicant or applicant's representative must cooperate with the department by providing information needed to determine eligibility. Cooperation includes:

(1) Completing an application form and any supplemental forms required by the department to determine eligibility.

(a) The applicant will be assisted by department staff in the completion of all required application forms when needed. All applicants will be screened to determine the need for necessary supplemental accommodation (NSA) services

and provided with such services as required under WAC 388-200-1300.

(b) Completed application forms must be signed:

(i) For food assistance, by an adult household member or minor applicant when there is no adult member;

(ii) For TANF, SFA and RCA, by all adult applicants and minor parents, if living in the home, of children for whom assistance is requested;

(iii) For GA-S and GA-U, by the applicant and spouse, if living in the home, whether or not assistance is being requested on behalf of the spouse;

(iv) For medical programs, by the applicant's relative or representative when the applicant dies or is otherwise unable to complete the application;

(v) An applicant's signature by mark requires two witnesses. The signatures of witnesses must appear on the form and be identified by the department as witnesses.

(2) Completing an interview if required under chapter 388-452 WAC;

(3) Providing additional information needed to determine eligibility as required under WAC 388-406-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0030 Requests for additional information. An applicant is allowed at least ten calendar days to provide additional information required by the department to determine eligibility. This information will be requested in writing and may include supplemental forms and documents or statements verifying the applicant's circumstances as specified in chapter 388-490 WAC. The applicant is allowed additional time to provide requested information when:

(1) The applicant has requested, orally or in writing, additional time to provide the information; or

(2) The department determines the need for different or additional information following the initial interview or after having requested specific information. In these situations, the applicant will be:

(a) Provided with a written request for the additional information; and

(b) Allowed at least ten calendar days to provide the information.

(3) When the applicant for medical and cash assistance has not provided all of the requested information, the applicant will be:

(a) Provided with a written request for information still needed to determine eligibility; and

(b) Allowed at least ten calendar days to provide the information.

(4) All applicants who are assessed as needing NSA services will be assisted in complying with the requirements of this section as required under WAC 388-200-1300.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0035 Time limits for processing applications. (1) The application process as defined in WAC 388-406-0050(1) must be completed as quickly as possible. The time limits specified in this section cannot be used as a waiting period for determining eligibility.

(2) When applying the time limits specified in this section, day one is the date following the date:

(a) A request for benefits form is received by the department as specified under WAC 388-406-0010;

(b) A household consisting solely of persons eligible for SSI files a food assistance application at the SSADO; or

(c) An SSI recipient applying for food assistance is released from a public institution when the person filed an application with the SSADO before release.

(3) Time limits are in calendar days unless otherwise specified. Time limits for application process completion are no more than:

(a) Thirty days for TANF, SFA, RCA, consolidated emergency assistance program (CEAP), and diversion cash assistance;

(b) Forty-five days for general assistance and alcohol and drug abuse treatment and shelter assistance (ADATSA); and

(c) Medical program benefits must be processed no more than:

(i) Sixty days when a disability decision is required;

(ii) Fifteen working days for pregnant women; and

(iii) Forty-five days for all other categories.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0035, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0470.]

WAC 388-406-0040 Delays in application processing.

(1) When the department discovers that a food assistance application has not been processed within the initial thirty day time limit, and:

(a) The department has sufficient information to determine eligibility, the application will be processed without further delay; or

(b) If additional information is needed to determine eligibility, the household will be:

(i) Mailed or given a written request for the additional information needed to determine eligibility; and

(ii) Allowed an additional thirty day period to provide the information.

(2) When a household files a joint application requesting food assistance and medical or cash assistance:

(a) Approval of the food assistance application cannot be delayed pending the processing of the application for medical or cash assistance; and

(b) A new application for food assistance cannot be required if the application for medical or cash assistance is denied.

(3) For medical and cash assistance, application processing may be delayed only when good cause exists as specified in WAC 388-406-0045.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

WAC 388-406-0045 Good cause for delay in processing medical and cash assistance applications. (1) Good cause reasons for delay in processing a medical or cash assistance application include:

(a) The applicant does not provide requested information or take another required action;

(b) The eligibility decision depends on medical reports and there is a delay in obtaining the reports or in securing medical information;

(c) An eligibility determination depends on correspondence with out-of-state or intercity contacts and no other verification is available for the eligibility factor;

(d) An administrative or other emergency occurs which is beyond the department's control; or

(e) For cash assistance, an eligibility determination depends on extensive property appraisals.

(2) For medical assistance, good cause exists only when the department otherwise acted promptly at all stages of the application process.

(3) For TANF and SFA, good cause exists only when the department:

(a) Notifies the applicant in writing of specific information needed to determine eligibility within twenty days of the date of application;

(b) Notifies the applicant in writing of the need for additional information or action within five calendar days;

(c) Determines eligibility and disposes of the application within five working days of receiving all information necessary to determine eligibility; and

(d) Determines good cause exists and documents the decision in the case record on or before the time limit for processing the application expires.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0045, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0480.]

WAC 388-406-0050 Completing the application process. (1) Application processing is completed when the department makes an eligibility decision and:

(a) Authorizes benefits and, for food assistance, mails or gives a written approval notice to the applicant; or

(b) Mails or gives a written withdrawal or denial notice to the applicant.

(2) The applicant will be notified of the department's eligibility decision in writing. A notice of denial or withdrawal must meet the adequate notice requirements in WAC 388-458-0005.

(3) For cash, medical, and food assistance, an applicant may voluntarily withdraw an application orally or in writing.

(4) For medical and cash assistance, an application is considered withdrawn when the applicant:

(a) Fails to appear for a scheduled interview required for eligibility determination; and

(b) Does not contact the department to reschedule the interview within thirty days from the date of application.

(5) For approved applications, the date the applicant becomes eligible for assistance is established according to WAC 388-406-0055.

(6) A decision to deny an application must be made according to the requirements of WAC 388-406-0060.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0050, filed 7/31/98, effective 9/1/98. Formerly WAC 388-525-2505.]

WAC 388-406-0055 Date of eligibility for approved applications. The effective date of eligibility for approved applications is:

- (1) For cash assistance, the earlier of:
 - (a) The date the department has sufficient information to make an eligibility decision; or
 - (b) The last day of the time limit period specified in WAC 388-406-0035.
- (2) For medical programs, as specified in chapter 388-416 WAC.
- (3) For food assistance, except as described in subsections (4) and (5) of this section:
 - (a) The first day of the month following the end of the previous certification period for:
 - (i) All households that reapply before their previous certification period ends; and
 - (ii) Migrant and seasonal farmworker households that reapply within one month after their previous certification period ends; or
 - (b) The date of application for all other households.
 - (4) For food assistance applications approved after reconsideration as required by WAC 388-406-0065:
 - (a) The date the household provides required verification when:
 - (i) The application is denied because the applicant fails to respond to a written request for the verification, and
 - (ii) The household provides the requested verification after the end of the initial thirty-day time limit; or
 - (b) The date the household becomes eligible for TANF or SFA when:
 - (i) The household is denied nonassistance food assistance; and
 - (ii) Is later found to be categorically eligible for food assistance because TANF or SFA is approved.

(5) For food assistance applications not processed within the thirty-day time limit, the first day of the month following the month of application when:

- (a) Required verification is not provided by the household by the end of the initial thirty-day time limit;
- (b) The household provides the required verification by the end of the second thirty-day period; and
- (c) The delay in providing the required verification is the fault of the household.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-406-0060 Denial of applications. (1) An application will be denied only when the department has not been able to establish the applicant's eligibility.

(2) An application cannot be denied solely because the applicant failed to provide requested information within a reasonably allowed period.

- (3) For medical and cash assistance:
 - (a) An application cannot be denied based on a delay in obtaining medical information if the delay in obtaining the information is beyond the control of the applicant and the department;
 - (b) A decision to deny an application will be delayed for good cause as specified in WAC 388-406-0045; and

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(c) An application for medical benefits will not be denied based on a failure to meet a spenddown obligation until at least thirty days after the end of the base period.

(4) If an applicant requests a fair hearing to contest the department's decision to deny an application because eligibility cannot be established based on information provided by the applicant, the issue in the hearing is whether the applicant can provide evidence to establish eligibility.

(5) Assistance will be denied to an entire assistance unit only when:

(a) Information required to establish eligibility for the entire assistance unit is not available to the department; or

(b) Circumstances which cause ineligibility affect all assistance unit members.

(6) An applicant will be notified of the department's decision to deny an application following notice requirements in WAC 388-458-0005.

(7) When an applicant for food assistance has not provided requested information within ten days:

(a) The application will be denied immediately if an application for TANF, SFA or SSI is not pending; or

(b) The denial decision may be delayed for up to thirty days from the date of application if an application for TANF, SFA or SSI is pending.

(8) A food assistance application which is not denied within the initial thirty-day period will be denied at the end of the second thirty-day period when:

(a) An eligibility decision could not be made based on information available to the department; and

(b) The applicant fails to provide requested information necessary to determine eligibility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0060, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0485.]

WAC 388-406-0065 Reconsideration of denied applications. (1) For medical and cash assistance, an applicant is allowed thirty days from the date of a denial notice to provide information needed to determine eligibility as specified in the notice.

(a) A redetermination of eligibility will be made and eligibility will be determined based on the information provided unless the applicant's circumstances have changed to the extent that additional information is needed to determine eligibility.

(b) If eligibility is approved based on the information provided, the eligibility date is based on the application date of the denied application.

(2) A denial of an application for medical benefits will be rescinded if the applicant, following the thirty-day period specified in subsection (1) of this section:

(a) Timely requests a fair hearing to appeal the denial; and

(b) Provides additional information needed to establish eligibility, including medical expenses sufficient to meet spenddown if the applicant shows reasonable cause for the delay in verifying the medical expenses.

(3) For food assistance, an applicant is allowed thirty days from the end of the initial thirty-day period to provide information needed to determine eligibility as specified in a

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denial notice. If the information is provided, the eligibility date is determined as specified under WAC 388-406-0055.

(4) A denied food assistance application will be re-evaluated within sixty days of the application date when the household was:

(a) Applying for both food assistance and TANF, SFA or SSI; and

(b) Denied food assistance before TANF, SFA or SSI was approved.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-406-0065, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0485.]

Chapter 388-408 WAC ASSISTANCE UNITS

WAC

388-408-0005	Definition of assistance unit for cash assistance programs.
388-408-0010	Assistance units for general assistance programs.
388-408-0015	Mandatory TANF and SFA assistance unit members.
388-408-0020	Persons excluded from TANF and SFA assistance units.
388-408-0025	Optional TANF and SFA assistance unit members.
388-408-0030	Consolidation of TANF and SFA assistance units.
388-408-0035	Assistance units for food assistance.
388-408-0040	Residents of institutions.
388-408-0045	Shelters for battered women and children.
388-408-0050	Homeless status for food assistance.
388-408-0055	Medical assistance units.

WAC 388-408-0005 Definition of assistance unit for cash assistance programs. A cash assistance unit is a person or group of persons who live together and whose income, resources, and needs are considered as a unit for the purpose of determining eligibility and the amount of the cash assistance payment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0010 Assistance units for general assistance programs. (1) A GA-S assistance unit includes only the pregnant woman.

(2) A GA-U assistance unit includes:

(a) An incapacitated adult; or

(b) A married couple if both persons are incapacitated and living together.

(3) A married couple living together must be included in a single assistance unit when:

(a) The husband is incapacitated; and

(b) The wife is pregnant and not eligible for TANF.

(4) A GA-H assistance unit includes only the child or children eligible for GA-H.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0015 Mandatory TANF and SFA assistance unit members. (1) A TANF assistance unit includes only a woman in her third trimester of pregnancy if there is no other eligible child in the home.

(2) A TANF, SFA or combined TANF/SFA assistance unit must include the following persons, if living together, unless the person must be excluded under WAC 388-408-

0020 or is excluded at the option of the family under WAC 388-408-0025:

(a) The child for whom assistance is requested and that child's full, half or adoptive siblings;

(b) Any natural or adoptive parent or stepparent of any child who is included in the assistance unit;

(c) Any parent of a pregnant minor or minor parent who claims to be the needy caretaker relative of:

(i) The pregnant minor or minor parent;

(ii) The minor parent's child; or

(iii) The pregnant minor or minor parent's full, half or adoptive sibling.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0020 Persons excluded from TANF and SFA assistance units. The following persons may not be included in a TANF or SFA assistance unit:

(1) Persons who are ineligible for reasons other than income and resources, except for adult family members who would make the family ineligible due to the TANF/SFA time limit as specified in chapter 388-484 WAC. Examples of persons who are ineligible for reasons other than income and resources are:

(a) Children who are not deprived of parental support and care as specified in chapter 388-430 WAC;

(b) Aliens who do not meet citizenship or alien status requirements for TANF or SFA as specified in chapter 388-424 WAC; and

(c) Children who do not live with relatives as specified in chapter 388-454 WAC.

(2) An adopted child if:

(a) The child receives federal, state or local adoption assistance; and

(b) Including the child would reduce the assistance unit's grant due to budgeting the adoption assistance income.

(3) Minor parents or children who have been placed in Title IV-E, state, or locally funded foster care except for temporary absences allowed for under WAC 388-454-0015;

(4) An adult parent in a two-parent household when:

(a) The other parent is unmarried and under the age of eighteen; and

(b) The department determines the living arrangement is not appropriate under WAC 388-486-0005.

(5) A recipient of SSI benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0025 Optional TANF and SFA assistance unit members. Unless excluded under WAC 388-408-0020, the following persons, if otherwise eligible, may be included in a TANF or SFA assistance unit at the option of the caretaker relative:

(1) One nonparental caretaker relative as defined in WAC 388-454-0010 if a parent of a child in the assistance unit does not reside in the home;

(2) The step siblings of a child included in the assistance unit;

(3) Children who are not siblings of a child included in the assistance unit;

- (4) The siblings of a child receiving SSI;
- (5) Any parent of a child receiving SSI;
- (6) One nonparental relative of specified degree of a child receiving SSI if the child's parent or parents are not living in the home;
- (7) One nonparental relative of specified degree of a child in the home receiving foster care; and
- (8) For recipient assistance units, the child of unmarried parents when the child is living with both parents.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0030 Consolidation of TANF and SFA assistance units. (1) All children included as mandatory or optional members and who live with the same caretaker relative or relative married couple must be included in a single assistance unit.

(2) Children do not have to be full, half, or adopted brothers or sisters to be included in the same assistance unit.

(3) When a change of circumstances occurs which makes one or more assistance unit members ineligible for cash assistance, assistance is continued for all assistance unit members who remain eligible.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0035 Assistance units for food assistance. (1) For food assistance, a household is:

- (a) A person living alone;
- (b) A group of people living together who purchase or prepare meals together;
- (c) A group of people living together who are required to be one household because of the relationship to each other as described in subsection (2) of this section; or
- (d) An elderly person with permanent disabilities who is unable to prepare meals. The combined income of all others living in the residence (excluding the spouse) cannot exceed the one hundred sixty-five percent standard under WAC 388-478-0060. The person's spouse must be included in the food assistance household.

(2) The following people living together must be one household even if they purchase and prepare meals separately:

(a) Spouses which means persons who are legally married or who present themselves as husband and wife to the community, friends and relatives;

(b) Parents and their children under twenty-two years of age regardless of the child's marital status; and

(c) Children under eighteen years of age and the adult who the child is living with when the adult is not the child's parent. When a minor child lives with an adult who is not the child's parent, the child is considered to be under parental control unless the child receives in their own name:

- (i) A TANF grant; or
- (ii) Gross income equal to or exceeding the TANF grant standard in WAC 388-478-0020(2).

(3) A household member who is absent from the household a full issuance month, is not eligible for benefits with that household.

(1999 Ed.)

(4) The following persons living in the residence are not household members and if eligible may be a separate food assistance household:

- (a) Roomers who are persons that pay for lodging but not meals;
- (b) Others who purchase and prepare meals separately from the household; or
- (c) Live-in attendants regardless of purchase and prepare arrangements.

(5) The following persons living in the residence are not household members and are not eligible for food assistance as a separate household:

- (a) Ineligible students; and
- (b) Persons eighteen to fifty years old without dependents who are no longer eligible for benefits as specified in chapter 388-444 WAC.

(6) A person who is living in the residence and is not a household member as described in subsection (4) and (5), is not included when household size, income eligibility, and benefit level are determined for the food assistance unit.

- (7) A boarder is a person who:
- (a) Is paying a reasonable amount for lodging and meals as determined by the department; or

(b) Is in foster care.

(8) A client can exclude a boarder at the client's request. If excluded, the boarder cannot be a separate food assistance household. Residents of licensed for-profit boarding homes are not eligible for benefits.

(9) The following household members are ineligible for food assistance and are considered ineligible members:

- (a) Those disqualified for:
 - (i) Intentional program violation (IPV) as specified in WAC 388-446-0015;
 - (ii) Noncompliance with work requirements as specified in WAC 388-444-0055; or
 - (iii) Failure to provide SSN as specified in WAC 388-476-0005;

(b) Those who fail to sign the application attesting to citizenship or alien status or immigrants not eligible because of alien status;

(c) Fleeing felons as specified in WAC 388-442-0010(1); or

(d) Those convicted of drug felonies as described under WAC 388-442-0010(2).

(10) A person who is living in the residence and is an ineligible household member is not included when household size and benefit level is determined.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0040 Residents of institutions. (1) Most residents of institutions are not eligible for food assistance benefits. Residents of the following institutions may be eligible:

- (a) Federally subsidized housing for the elderly;
- (b) Qualified drug and alcohol treatment centers when an employee of the treatment center is the authorized representative;
- (c) Qualified group homes for persons with disabilities;

[Title 388 WAC—p. 543]

(d) A shelter for battered women and children when the resident left the home that included the abuser; or

(e) Nonprofit shelters for the homeless. Homeless clients may use food stamps to purchase prepared meals from meal providers for the homeless.

(2) A qualified group home is a nonprofit residential facility that:

(a) Houses sixteen or fewer persons with disabilities as defined under WAC 388-400-0040(6); and

(b) Is certified by the division of developmental disabilities (DDD).

(3) Elderly or disabled household members and spouses may use food stamps to purchase meals from the following when approved by FNS:

(a) Communal dining facility; or

(b) Nonprofit meal delivery service.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0045 Shelters for battered women and children. (1) Persons living in a shelter for battered women and children may receive food assistance.

(2) A shelter resident who left a food assistance household that included the abuser:

(a) Is certified as a separate household;

(b) May receive an additional allotment even when the resident already received benefits with the abuser; and

(c) Are certified on the basis of:

(i) Income and resources to which they have access; and

(ii) Expenses for which they are responsible.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0050 Homeless status for food assistance. A client is considered homeless when they do not have a regular nighttime residence or when they stay primarily in a:

(1) Supervised shelter that provides temporary living or sleeping quarters;

(2) Halfway house providing temporary residence for persons going into or coming out of an institution;

(3) Residence of another person that is temporary and the client has lived there for ninety days or less; or

(4) A place not usually used as sleeping quarters for humans.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-408-0055 Medical assistance units. (1) A medical assistance unit (MAU) is determined on the basis of relationship and financial responsibility.

(a) Married persons, living together are financially responsible for each other;

(b) Parents are financially responsible for their unmarried, minor children living in the same household;

(c) A parent's financial responsibility is limited when their minor child is receiving inpatient chemical dependency or mental health treatment. Only the income a parent chooses to contribute to the child is considered available when:

(i) The treatment is expected to last ninety days or more;

(ii) The child is in court-ordered out-of-home care in accordance with chapter 13.34 RCW; or

(iii) The department determines the parents are not exercising responsibility for the care and control of the child.

(d) Minor children are not financially responsible for their parents or for their siblings.

(2) Certain situations require the establishment of separate MAUs for some family members living in the same household. Separate MAUs are established for:

(a) A pregnant minor, regardless of whether she lives with her parent(s);

(b) A child with income;

(c) A child with resources which makes another family member ineligible for medical assistance;

(d) A child of unmarried parents when both parents reside with the child;

(e) Each unmarried parent of a child in common, plus any of their children who are not in separate MAUs;

(f) A nonresponsible caretaker relative;

(g) SSI recipients or persons related to SSI from the non-SSI related family members;

(h) The purpose of applying medical income standards for an:

(i) SSI-related applicant whose spouse is not relatable to SSI or is not applying for SSI-related medical; and

(ii) Ineligible spouse of an SSI-recipient.

(3) Only the parent's income actually contributed to a pregnant minor is considered income to the minor.

(4) A parent's income up to one hundred percent of the Federal Poverty Level (FPL) is allocated to the parent and other members of the parent's MAU. The excess is allocated among their children in separate MAUs.

(5) A parent's resources are allocated equally among the parent and all persons in the parent's household for whom the parent is financially responsible. This includes family members in separate MAUs.

(6) Countable income for medical programs is described in WAC 388-450-0150 and 388-450-0210.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-408-0055, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0610, 388-506-0630 and 388-507-0730.]

Chapter 388-410 WAC
BENEFIT ERROR

WAC

388-410-0001	Cash/medical assistance overpayments.
388-410-0005	Cash and medical assistance overpayment amount and liability.
388-410-0010	Repayment of grant overpayment occurring prior to April 3, 1982, and resulting department error.
388-410-0015	Recovery of cash assistance overpayments by mandatory grant deduction.
388-410-0020	Food assistance overpayments.
388-410-0025	Food assistance overpayment liability.
388-410-0030	Food assistance overpayment amount and recovery.
388-410-0035	Alien and alien sponsor cash, and food assistance overpayments.
388-410-0040	Cash and food assistance underpayments.

WAC 388-410-0001 Cash/medical assistance overpayments. (1) An overpayment means any assistance paid to an assistance unit where:

(a) Eligibility for the payment did not exist; or

- (b) Assistance paid was in excess of need.
- (2) There are two different types of overpayments for cash and medical assistance:
 - (a) Intentional overpayments; and
 - (b) Unintentional overpayments.
- (3) The client is presumed to have committed an intentional overpayment when the client willfully or knowingly:
 - (a) Fails to report within twenty days a change in circumstances that affects the client's eligibility or need; or
 - (b) Misstates or fails to reveal a material fact that affects eligibility or need as specified in WAC 388-446-0001.
- (4) All overpayments that are not due to the willful or knowing failure of the client to provide information necessary to determine eligibility are considered unintentional overpayments.

(5) Child support payments received directly from the absent parent are not treated as a grant overpayment if kept by the caretaker relative. Such payments are considered a debt to the division of child support.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0005 Cash and medical assistance overpayment amount and liability. (1) The amount of overpayment for cash and medical assistance households is determined by the amount of assistance received to which the assistance unit was not entitled.

(2) Cash and medical assistance overpayments are recovered from:

- (a) Any individual member of an overpaid assistance unit, whether or not the member is currently a recipient; or
- (b) Any assistance unit of which a member of the overpaid assistance unit has subsequently become a member.

(3) A cash or medical assistance overpayment is not recovered from:

(a) A nonneedy caretaker relative or guardian who received no financial benefit from the payment of assistance; or

(b) A person not receiving assistance when an unintentional overpayment of less than thirty-five dollars is discovered and/or computed.

(4) Overpayments resulting from incorrectly received cash assistance are reduced by:

(a) Cash assistance a household would have been eligible to receive from any other category of cash assistance during the period of ineligibility; and

(b) Child support the department collected for the month of overpayment in excess of the amount specified in (a) of this subsection; or

(c) Any existing grant underpayments.

(5) A cash assistance overpayment cannot be reduced by a medical or food assistance underpayment.

(6) A medical assistance overpayment cannot be reduced by a cash or food assistance underpayment.

(7) An underpayment from one assistance unit cannot be credited to another assistance unit to offset an overpayment.

(8) All overpayments occurring after January 1, 1982 are required to be repaid by mandatory grant deduction except where recovery is inequitable as specified in WAC 388-410-0010.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0010 Repayment of grant overpayment occurring prior to April 3, 1982, and resulting department error. (1) An assistance unit will not be held liable for an overpayment occurring prior to April 3, 1982, which was caused by departmental error, until the department determines recovery would not be inequitable. Recovery is considered inequitable if:

(a) The department informed the recipient or the recipient's authorized representative that the recipient was entitled to part or all of the financial assistance or services overpaid; or

(b) The department acted in a manner which would reasonably lead the recipient to believe he/she was eligible to receive the assistance or services overpaid; and

(c) The recipient retained or accepted the assistance with the understanding that he/she had the right to rely upon the information received from the department; and

(d) The recipient would suffer an injury if the department were allowed to refuse to recognize the department's admission, statement, act or omission; and

(e) Injury as used in this section includes liability for repayment of a debt due the state.

(2) If the department determines recovery would be inequitable:

(a) The recipient is not liable for repayment;

(b) The overpayment is not a debt due the state; and

(c) The recipient is so informed.

(3) If recovery would not be inequitable, the recipient will be notified:

(a) Of the specific reason why recovery is not inequitable;

(b) That the recipient is liable for repayment of the debt;

(c) Whether the overpayment is subject to a mandatory deduction from the current grant; and

(d) Of the right to contest the decision.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0015 Recovery of cash assistance overpayments by mandatory grant deduction. (1) All overpayments of cash assistance are recovered by means of a mandatory deduction from future continuing assistance grants except as specified by WAC 388-410-0010.

(2) All members of an overpaid assistance unit are responsible for repayment of an overpayment. Repayment may be from:

(a) Resources and/or income; or

(b) Deductions from subsequent grants; and

(c) An assistance unit member's estate.

(3) The mandatory grant deduction of an intentional overpayment is ten percent of the monthly grant payment standard.

(4) A monthly grant deduction of up to one hundred percent of the grant can be established when:

(a) The overpayment is intentional;

(b) The client has liquid resources available but refuses to use these resources in full or partial satisfaction of the overpayment; and

(c) The amount of income and resources remaining available to the assistance unit is not less than ninety percent of the grant payment standard.

(5) An unintentional overpayment is recovered by grant deduction of five percent of the monthly grant payment standard unless the client voluntarily requests a larger deduction in writing.

(6) A monthly deduction for overpayment recovery can be established against the clothing and incidental grant of a recipient in a nursing facility, intermediate care facility, or hospital. A monthly deduction cannot be established against the vendor payment to the nursing facility, intermediate care facility or hospital.

(7) When the monthly grant deduction is equal to or more than the current grant for which the client is eligible had no overpayment occurred, the grant is suspended.

(8) No more than the total amount of an overpayment may be collected by mandatory deduction from a client's public assistance grant. The client will receive compensation for an underpayment resulting from any erroneous monthly deduction.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0020 Food assistance overpayments. There are three different types of overpayments in the food assistance program. These types are:

(1) An administrative error overpayment defined as an overpayment caused solely by:

(a) The department's action or failure to act causing an incorrect determination of categorical eligibility (CE); and

(b) A resulting claim which can be computed based on a change in net income or assistance unit size.

(2) An inadvertent household error overpayment defined as any overpayment caused by either misunderstanding or unintended error by a household that is:

(a) The result of Social Security Administration (SSA) action or failure to act causing an incorrect determination of CE; and

(b) A resulting claim which can be computed based on a change in net income or assistance unit size.

(3) An intentional program violation overpayment defined as any overpayment resulting from an intentional program violation as specified under chapter 388-446 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0025 Food assistance overpayment liability. (1) Food assistance overpayment claims are established against any assistance unit:

(a) Receiving more food assistance benefits than it was entitled to receive; or

(b) Containing an adult member who was an adult member of another assistance unit receiving more benefits than it was entitled to receive.

(2) All persons who were adult members of a food stamp assistance unit at the time of a food stamp overpayment are

jointly and separately liable and are subject to collection action.

(3) A food assistance administrative error claim or inadvertent household error claim cannot be established unless the assistance unit:

(a) Signed the application form; and

(b) Was certified by the community service office (CSO) in the correct catchment area; or

(c) Cashed an expired food coupon authorization card that was altered by the assistance unit.

(4) An administrative error overpayment is established when:

(a) Discovered within twelve months of its occurrence; and

(b) The household is mailed a recovery demand letter and the overpayment is calculated within twenty-four months of discovery.

(5) An inadvertent household error overpayment is established when:

(a) Discovered within twenty-four months of its occurrence; and

(b) The household is mailed a recovery demand letter and the overpayment is calculated within twenty-four months of discovery.

(6) An intentional program violation overpayment is established when:

(a) Discovered within seventy-two months of its occurrence; and

(b) The household is mailed a recovery demand letter and the overpayment is calculated within twenty-four months of discovery.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0030 Food assistance overpayment amount and recovery. (1) The amount of a food assistance overpayment is determined by counting the difference between:

(a) The allotment actually authorized; and

(b) The allotment that should have been authorized.

(2) The monthly allotment the assistance unit should have been authorized is determined counting the actual income received by the assistance unit.

(3) A food assistance overpayment can be reduced by a food assistance underpayment if the underpayment was:

(a) Not previously restored; or

(b) Already used to reduce an overpayment.

(4) All inadvertent household or administrative error claims are subject to collection unless:

(a) The entire overpayment claim is cancelled by an underpayment;

(b) The administrative error claim is less than one hundred dollars;

(c) The inadvertent household error claim is less than thirty-five dollars;

(d) The department cannot locate the liable household; or

(e) An attempt to collect will prejudice an inadvertent household error case referred for possible prosecution or administrative disqualification.

(5) An intentional program violation is subject to collection action against the liable assistance unit unless:

(a) The assistance unit has repaid the overpayment;

(b) The assistance unit cannot be located; or

(c) The department determines collection action will prejudice the case against an assistance unit member referred for prosecution.

(6) An assistance unit or assistance unit member may repay an overpayment by:

(a) A lump sum;

(b) Regular installments under a payment schedule as specified in subsection (7) of this section; or

(c) Allotment reduction.

(7) Currently participating food assistance units liable for an inadvertent household error or intentional program violation overpayment may repay by a negotiated monthly installment amount. The repayment amount must not be less than the amount that could be recovered through allotment reduction. The payment schedule may be renegotiated by either the department or the assistance unit member.

(8) Food assistance units repaying overpayments by allotment reduction will repay:

(a) An administrative error overpayment by an amount agreed to by the assistance unit;

(b) An inadvertent household error overpayment by the greater of:

(i) Ten percent of the assistance unit's monthly allotment; or

(ii) Ten dollars per month.

(c) An intentional program violation overpayment by the greater of:

(i) Twenty percent of the household's monthly allotment; or

(ii) Ten dollars per month.

(9) Involuntary reduction of the allotment an assistance unit is currently receiving is authorized when the household is liable for an inadvertent household error; and

(a) Fails to notify the department of their chosen repayment agreement; or

(b) Fails to request a fair hearing and continued benefits within twenty days of receipt of notice from the department of collection action.

(10) An assistance unit that is liable for an intentional program violation claim must chose a repayment agreement within ten days of receipt of notice of collection action. Failing to do so will subject the assistance unit to involuntary reduction of their current food assistance allotment.

(11) A household that fails to meet the terms of an agreed repayment schedule is subject to involuntary reduction of their current food assistance allotment unless:

(a) Overdue payments are caught up; or

(b) The household requests renegotiation of the payment schedule.

(12) Collection action is suspended when:

(a) A liable household member cannot be located; or

(b) Cost of further collection action is likely to exceed the amount that can be recovered.

(13) The amount of an overpayment can be negotiated if the amount offered approximates the net amount expected to

be collected prior to the expiration of the collection period by statute.

(14) Prior to the expiration of the collection period, unpaid overpayments are written off and any applicable liens are released when:

(a) There is no further possibility of collection;

(b) There was an accepted offer of compromise leaving an unpaid balance after payment; or

(c) There is an unpaid balance remaining after a case has been in suspense for three consecutive years.

(15) Food assistance overpayments occurring in another state may be collected in this state if the originating state does not intend to pursue collection and provides the following:

(a) Documentation of the overpayment computation and overpayment notice prepared for the client; and

(b) Proof of service showing the client received the overpayment notice.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0035 Alien and alien sponsor cash, and food assistance overpayments. (1) An alien and their sponsor are jointly and individually liable for any overpayment of cash or food assistance made to the alien during the three years after the alien's entry into the United States.

(2) When an overpayment to a sponsored alien results from incorrect information provided by the alien's sponsor, both the alien and the sponsor are liable for repayment.

(3) When the alien's sponsor had good cause for reporting the incorrect information, the sponsored alien is solely liable for an inadvertent household error overpayment.

(4) When good cause does not exist, collection action is initiated against:

(a) The alien's sponsor; or

(b) The sponsored alien's assistance unit; or

(c) Of the two, the one considered most likely to repay first.

(5) Collection action is initiated against an alien's sponsor for an inadvertent household error when:

(a) A department representative contacts the sponsor in person or by phone; and

(b) The sponsor is informed in writing there will be no responsibility for repayment if good cause for reporting incorrect information causing the overpayment can be demonstrated.

(6) Collection action is initiated against the sponsored alien's assistance unit for an inadvertent household error when:

(a) Collection action is taken first against the alien's sponsor; and

(b) The alien's sponsor does not respond within thirty days; or

(c) The sponsored alien provides incorrect information concerning the sponsor or sponsor's spouse through misunderstanding or unintended error.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-410-0040 Cash and food assistance underpayments. (1) All cash assistance underpayments not credited against an overpayment are repaid upon discovery to any current or former recipient.

(2) All food assistance benefits underpaid are restored when:

- (a) An underpayment was caused by department error;
- (b) An administrative disqualification for intentional program violation was reversed;
- (c) A rule or instruction specifies restoration of unpaid benefits; or

(d) A court action finds benefits were wrongfully withheld.

(3) A client is eligible for restoration of underpaid benefits for any of the twelve months prior to:

- (a) The month the client requests restoration;
- (b) The month the department discovers an underpayment;
- (c) The date the household makes a fair hearing request when a request for restoration of benefits was not received; or
- (d) The date court action was started when the client has taken no other action to obtain restoration of benefits.

(4) The client may request a fair hearing if they disagree with the amount of benefits the department determines were underpaid.

(5) If household composition changes prior to the department's restoration of an underpayment, the underpayment is paid to:

- (a) First, the household containing a majority of the persons who were household members at the time of the underpayment; or
- (b) Second, the household containing the head of the household at the time of the underpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-410-0040, filed 7/31/98, effective 9/1/98.]

Chapter 388-412 WAC BENEFIT ISSUANCES

WAC

388-412-0005	General information about [for] cash assistance payments.
388-412-0010	Endorsing the warrant.
388-412-0015	Food assistance allotments.
388-412-0020	How cash assistance benefits are delivered.
388-412-0025	Issuing food assistance benefits.
388-412-0030	Returning a warrant.
388-412-0035	Loss, theft, destruction or nonreceipt of a warrant issued to clients and vendors.
388-412-0040	Replacing lost, stolen, or destroyed food assistance allotments.
388-412-0045	General information about cash and food assistance issued by electronic benefits transfer.

WAC 388-412-0005 General information about [for] cash assistance payments. (1) Eligible clients may receive cash assistance by electronic benefit transfer (EBT) or warrants [Each separate assistance receives a separate cash benefit grant, even if there are multiple assistance units in the same residence].

(2) Each separate assistance unit receives a separate cash benefit grant, even if there are multiple assistance units in the same residence.

[Title 388 WAC—p. 548]

(3) A married couple who both receive any general assistance benefit must be considered one assistance unit. However, cash payments are made individually and will not exceed one half of the two-person GA-U standard.

(4) Grants are rounded down to the next whole dollar amount with the following exceptions:

- (a) Clothing and personal incidental (CPI) allowance; and

(b) Grants with a deduction for repayment of an overpayment.

(5) Grant payments are not issued for under ten dollars except:

- (a) Grants with a deduction for repayment of an overpayment;

(b) CPI allowances with income deducted; or

(c) Supplemental Social Security (SSI) interim assistance payments.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0005, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0005, filed 7/31/98, effective 9/1/98.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 388-412-0010 Endorsing the warrant. (1) Clients must endorse their warrants unless they have executed a power of attorney. If a client has given someone else a power of attorney, the client must give the department a copy.

(2) If a client is unable to sign the warrant, it must be endorsed by the client's mark or thumb print witnessed by two people. The witnesses must give their names and addresses to the person that cashes the warrant.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0015 Food assistance allotments. (1) A client's food assistance benefit amount is called an allotment. An allotment is the total dollar value of coupons an eligible assistance unit receives for a calendar month.

(2) Assistance units with no income receive the maximum allotment as described under the thrifty food plan (TFP) in WAC 388-478-0060. Assistance units with net income receive smaller amounts.

(3) When an assistance unit has income, the allotment is determined by:

(a) Multiplying the assistance unit's net monthly income by thirty percent and rounding down that amount to the next whole dollar; and

(b) Subtracting the results from the thrifty food plan for the appropriate assistance unit size as specified in WAC 388-478-0060.

(4) Except for those described in WAC 388-406-0055 eligible assistance units receive benefits from the effective date of eligibility to the end of the first month. This is called proration and is based on a thirty-day month.

(5) In the first month of eligibility, assistance units do not receive an allotment when the amount is less than ten dollars.

(6) Eligible one and two person assistance units receive a minimum ten dollar allotment:

(a) After the first month of eligibility; or

(b) In the first month of eligibility when the CSO receives the assistance unit's application on the first day of the month.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0020 How cash assistance benefits are delivered. Depending on the circumstances of the assistance unit, the department decides when cash assistance benefits are:

(1) Mailed by warrant to the address where clients live except when:

(a) The department redirects the benefit issuance to the local office;

(b) The department has established there are problems with receiving mail at the client's address;

(c) A client requests in writing that the benefit issuance be mailed to the local office, such as a homeless client without an address; or

(d) A client requests that the benefit issuance be sent to a temporary address for less than ninety days.

(2) Deposited directly into an electronic benefit transfer account.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0020, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0025 Issuing food assistance benefits.

(1) An eligible assistance unit is issued benefits by means of:

(a) A food coupon authorization (FCA) card that must be redeemed for food coupons;

(b) Food coupons mailed directly to the client; or

(c) Electronic benefit transfers (EBT).

(2) Clients are issued food assistance benefits during the first ten days of the month.

(3) A client must redeem an FCA for coupons during the period that is specified on the FCA card.

(4) Eligible clients applying on or after the 16th of the month are issued one allotment called a combined issuance that includes benefits for:

(a) The month of application; and

(b) The following month.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0030 Returning a warrant. (1) A person who has possession of a warrant payable to a deceased payee must return the warrant to the department for cancellation.

(2) A person who has possession of a warrant payable to an assistance unit payee who has left the home and is not likely to return during the month to endorse the warrant,

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must return the warrant to the CSO. The warrant may be reissued to another eligible payee for the assistance unit.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0030, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0035 Loss, theft, destruction or non-receipt of a warrant issued to clients and vendors. The following applies to replacements of warrants issued to clients and to vendors.

(1) The department does not replace a warrant or the cash proceeds from a warrant which was endorsed by a client or vendor.

(2) Clients or vendors asking for a replacement of a warrant which was not endorsed by them must:

(a) Complete a notarized affidavit;

(b) Provide all facts surrounding the loss, theft, destruction or nonreceipt of the warrant; and

(c) File a report with the police or the post office, as appropriate.

(3) If a client is eligible to receive a replacement, the warrant is issued:

(a) On or before the tenth of the month in which the warrant was due; or

(b) Within five working days of the date the decision is made to replace the warrant, whichever is later.

(4) A client or vendor is issued the full amount of the original warrant if the warrant is replaced.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0035, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0040 Replacing lost, stolen, or destroyed food assistance allotments. (1) A client may receive a replacement for a one month food assistance allotment when:

(a) An FCA or food coupons are lost or stolen from the mail;

(b) An FCA is stolen after receipt; or

(c) An FCA card, coupons or food purchased with coupons are destroyed in a disaster.

(2) To get a replacement, a client must:

(a) Report the theft or destruction within ten days of the incident; or

(b) Report nonreceipt of the benefits within the period that benefits are intended to be used; and

(c) Sign a department affidavit within ten days of the report attesting to the loss.

(3) A client's request for a replacement is denied when:

(a) Certified mail coupons are signed for by any person residing or visiting at the address provided by the client;

(b) Coupons or an FCA card are lost or misplaced after receipt;

(c) Coupons are stolen after receipt;

(d) A client already received two replacements described in subsection (1) above within the previous five months; or

- (e) The request is determined to be fraudulent.
- (4) A client cannot receive a disaster food stamp program allotment and a replacement allotment for the same period.
- (5) A replacement as specified in subsection (1) will not count against an assistance unit when:
 - (a) An allotment is returned to the department;
 - (b) The original or replacement FCA is not cashed;
 - (c) The replacement is issued because of a department error;
 - (d) A partial coupon delivery is caused by a department error; or
 - (e) The coupons delivered are improperly made or are mutilated. There must be at least three-fifths of the each coupon to turn in for an exchange.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-412-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-412-0045 General information about cash and food assistance issued by electronic benefits transfer.

- (1) The department may decide which assistance unit gets cash assistance payment by warrant or EBT.
- (2) All food assistance benefits are issued by EBT.
- (3) The department establishes an EBT account for each assistance unit and provides information about how to use the account.
- (4) EBT benefits reported lost or stolen are replaced for the amount of the loss only when:
 - (a) The department makes an error that causes a loss of benefits; or
 - (b) Both the EBT card and personal identification number (PIN) are stolen from the mail; and
 - (c) The client never had the ability to access the benefits; and
 - (d) The loss is reported within ten days from the date the client became aware of the loss.

(5) The department does not replace benefits which have been deposited into an electronic benefit account and are available to the client. The benefits are considered to be cash or coupons.

(6) The EBT account becomes inactive when it is not used for ninety days. After ninety days, the client must ask the department to reactivate the account to use the benefits.

(7) Food assistance benefits are canceled and will not be replaced when the EBT account is not used for two hundred seventy days.

(8) If a client moves to an area where EBT benefits cannot be used, the client may ask the department to convert EBT food assistance benefits to food coupons. Because food coupon books are certain values, there may be a small amount left in the EBT account after converting the benefits. If the remaining benefits are not used within seven days from the date of conversion, the remaining benefits will be canceled.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-412-0045, filed 12/31/98, effective 1/3/99.]

Chapter 388-414 WAC

CATEGORICAL ELIGIBILITY FOR FOOD ASSISTANCE

WAC

388-414-0001 Food assistance categorical eligibility.

WAC 388-414-0001 Food assistance categorical eligibility. (1) A food assistance unit is categorically eligible (CE) to receive food benefits when all members are authorized to receive a cash benefit under any of the following cash programs:

- (a) Temporary assistance for needy families (TANF);
- (b) State family assistance (SFA);
- (c) Supplemental Security Income (SSI); or
- (d) General assistance cash programs.

(2) Some food assistance units are not categorically eligible to receive food benefits even after meeting the requirements in subsection (1) of this section. Categorical eligibility does not happen when the entire assistance unit or any member of the unit fits into the following situations:

- (a) The entire food assistance unit is:
 - (i) Living in an institution;
 - (ii) Disqualified from receiving food assistance for any reason; or
 - (iii) Terminated from food assistance because of failure to meet monthly reporting requirements.

- (b) Any member of the food assistance unit is:
 - (i) Disqualified from food assistance for an intentional program violation (IPV);
 - (ii) Disqualified from food assistance because of failure to meet work registration requirements;
 - (iii) Not eligible for food assistance because of their alien or student status; or
 - (iv) Receiving SSI as an essential person or an ineligible spouse, not eligible for SSI on their own behalf.

(3) A categorically eligible assistance unit has already met cash eligibility requirements. Some requirements are similar for food assistance. A food assistance unit determined to be categorically eligible does not have to meet food assistance eligibility requirements regarding:

- (a) Residency;
- (b) Social security number;
- (c) Sponsored alien;
- (d) Resources; and
- (e) The gross and net income standards.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-414-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-416 WAC
CERTIFICATION PERIODS

WAC

388-416-0005	Certification periods for food assistance.
388-416-0010	Medical certification periods for recipients of cash assistance programs.
388-416-0015	Certification periods for categorically needy (CN) programs.
388-416-0020	Certification periods for noninstitutionalized medically needy (MN) program.
388-416-0025	Certification period for children's health program.
388-416-0030	Certification periods for the medically indigent (MI) program.

388-416-0035 Certification periods for Medicare cost sharing programs.

WAC 388-416-0005 Certification periods for food assistance. A certification period is the specified time the assistance unit is determined eligible. Assistance units are certified for:

- (1) Up to twenty-four months for assistance units without earned income and all members are elderly;
- (2) Up to twelve months for assistance units:
 - (a) Receiving cash assistance;
 - (b) With earned income and required to report monthly; or
 - (c) Without earned income and all household members are disabled or elderly.
- (3) Up to six months for:
 - (a) Assistance units with recent work history and required to report monthly; or
 - (b) Assistance units not likely to have any changes.
- (4) Up to three months for assistance units:
 - (a) Consisting of migrants; or
 - (b) All other assistance units not included in this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-416-0010 Medical certification periods for recipients of cash assistance programs. (1) The certification period for medical services begins on the first day of the month of application when the client is determined eligible for cash assistance for one of the following programs:

- (a) Temporary assistance for needy families (TANF) or state family assistance (SFA); or
- (b) Supplemental Security Income (SSI); or
- (c) General assistance for pregnant women (GA-S); or
- (d) General assistance for children (GA-H); or
- (e) Refugee assistance.

(2) The certification period for the medical programs associated with the cash programs in subsection (1) of this section continues as long as eligibility for these programs lasts. When a client's cash assistance is terminated, eligibility for medical assistance is continued until eligibility is redetermined as described in WAC 388-418-WAC.

(3) The certification period for medical can begin up to three months prior to the month of application for clients described in subsection (1) of this section if the conditions in WAC 388-416-0015(6) apply.

(4) The certification period for medical care services begins on the date eligibility begins for the following cash assistance programs:

- (a) General assistance for unemployable persons (GA-U); or
- (b) Alcohol and drug abuse treatment and support act (ADATSA) programs, when the client is either receiving a grant or waiting for treatment to begin.

(5) The certification period for medical care services for clients in subsection (4) of this section runs concurrently with the period of eligibility for the client's cash assistance program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0010, filed 7/31/98, effective 9/1/98. For-

merly WAC 388-521-2110, 388-521-2120, 388-522-2210 and 388-524-2420.]

WAC 388-416-0015 Certification periods for categorically needy (CN) programs. (1) Eligibility for categorically needy (CN) medical assistance begins on the first day of the month of application. Eligibility ends on the last day of the last month of the certification period.

(2) TANF/SFA-related, and SSI-related CN medical are each certified for twelve months.

(3) The pregnant women's program is certified through the end of the month which includes the sixtieth day from the day the pregnancy ends.

(4) The children's medical program is certified for twelve months or through the end of the month the child turns nineteen, whichever is earlier. This period can be extended when:

(a) The child is receiving inpatient services on the last day of the month when the child turns nineteen; and

(b) The inpatient stay continues into the following month or months; and

(c) The child remains eligible except for exceeding the age requirement.

(5) The newborn medical program is certified through the end of the month that the newborn turns one year old.

(6) The certification period can begin up to three months immediately prior to the month of application when:

(a) The client would have been eligible for medical assistance, had the client applied;

(b) The client received medical services which are covered by DSHS, as described in WAC 388-529-0100; and

(c) If eligibility is only for a retroactive period, that period is the only period of certification.

(7) Any months of a retroactive certification period are added to the designated certification period.

(8) Medical assistance is continued until eligibility is redetermined as described in chapter 388-418 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0015, filed 7/31/98, effective 9/1/98. Formerly 388-509-0970, 388-521-2105, 388-522-2210 and 388-522-2230.]

WAC 388-416-0020 Certification periods for noninstitutionalized medically needy (MN) program. (1) The certification period for the noninstitutionalized medically needy (MN) program begins:

(a) On the first day of the month in which hospital expenses equal the spenddown amount; or

(b) On the day that spenddown is met, when hospital expenses are less than the spenddown amount or no hospital expenses are involved.

(2) The certification period continues through the last day of the final month of the base period as described in chapter 388-519 WAC.

(3) The certification period can begin up to three months immediately prior to the month of application as described in chapter 388-519 WAC.

(4) The certification period for MN clients with income below the medically needy income level (MNIL) is twelve months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2105 and 388-521-2130.]

WAC 388-416-0025 Certification period for children's health program. (1) The certification period for the children's health program begins on the first day of the month of application.

(2) The certification period continues for twelve months or through the end of the month the child turns eighteen, whichever is earlier. This period can be extended as described in WAC 388-416-0015(4).

(3) The certification period can begin up to three months immediately prior to the month of application, as described in WAC 388-416-0015 (6) and (7).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-509-0970, 388-519-1905, 388-521-2106 and 388-522-2210.]

WAC 388-416-0030 Certification periods for the medically indigent (MI) program. (1) A client must meet the emergency medical expense requirement (EMER), before eligibility can be determined for the medically indigent (MI) program.

(2) If the client is not required to spenddown excess income or resources, the certification period for MI begins on the date that the EMER was met.

(3) When an MI applicant must satisfy a spenddown amount, the certification period begins:

(a) On the first day of the month in which hospital expenses (excluding the EMER) equal the spenddown amount; or

(b) On the day that spenddown is met, when hospital expenses are less than the spenddown amount.

(4) The certification period cannot exceed three calendar months in a twelve month period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0030, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2140.]

WAC 388-416-0035 Certification periods for Medicare cost sharing programs. (1) The certification period for the qualified Medicare beneficiary (QMB) program:

(a) Is for twelve months; and

(b) Begins the first day of the month following the month of QMB eligibility determination; and

(2) The certification period for the qualified disabled working individual (QDWI) program:

(a) Is twelve months; and

(b) May begin up to three months prior to the month of application if on the first day of the first month of the certification period the person:

(i) Is or had been enrolled in Medicare Part A; and

(ii) Meets or has met the department's eligibility requirements for QDWI.

(3) The certification period for the:

(a) Special low income medicare beneficiary (SLMB) program is twelve months in duration;

(b) Expanded special low income medicare beneficiary (ESLMB) program extends to the end of the calendar year.

(4) The certification periods for SLMB and ESLMB may begin up to three months prior to the month of application if on the first day of the first month of the certification period the person:

(a) Is or has been enrolled in Medicare Part B; and

(b) Meets or has met the department's eligibility requirements for SLMB or ESLMB.

(5) The certification period for SLMB coverage is twelve months in duration.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-416-0035, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2150, 388-521-2155 and 388-521-2160.]

Chapter 388-418 WAC

CHANGE OF CIRCUMSTANCE

WAC

388-418-0005	Reporting requirements.
388-418-0010	Requesting information or action needed.
388-418-0015	Recipient fails to provide requested information or take requested action.
388-418-0020	Effective dates for changes.
388-418-0025	Effect of changes on medical.
388-418-0030	Notifying a recipient of intent to reduce, suspend or terminate assistance.

WAC 388-418-0005 Reporting requirements. (1) For cash and food assistance:

(a) Clients must report changes within ten days of the date the change becomes known to the assistance unit.

(b) Clients who report changes on a monthly report as specified under chapter 388-456 WAC are not required to report within the ten-day period.

(2) For medical care services, clients must report changes within twenty days of the date the change becomes known to the client.

(3) Food assistance clients are required to report the following:

(a) A change in the amount of gross monthly income of more than twenty-five dollars except for changes in public assistance income;

(b) A change in the source of income;

(c) A change in household size such as addition or loss of a household member;

(d) A change in residence and the resulting change in shelter cost;

(e) Obtaining a licensed vehicle;

(f) The end of a temporary disability when the temporary disability is the reason for excluding a vehicle; and

(g) When a change in the assistance unit's countable liquid resources exceeds the applicable resource limit as described under WAC 388-470-0005.

(4) For TANF/SFA, a caretaker relative must report the absence of a child within five days of the date that it becomes reasonably clear that the absence will exceed ninety days. If the relative fails to report timely, the relative:

(a) Is not eligible for one month; and

(b) The relative's countable income will be considered available to the remaining members of the assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0010 Requesting information or action needed. (1) A recipient must receive a written request for any information or action needed to maintain continuing eligibility.

(2) A recipient is allowed at least ten days from the date the request is mailed to provide the information or take the required action.

(3) The request must state:

(a) The information or action needed;

(b) The date the information must be provided or action taken; and

(c) That failure to provide the information or take the action requested may result in termination or reduction of benefits.

(4) The recipient's cash, medical and/or food assistance may be reduced, suspended, or terminated if the recipient:

(a) Does not take the action or provide the information within the ten day period; or

(b) Provides information or action which is inadequate or the information results in reduction or termination of benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0015 Recipient fails to provide requested information or take requested action. (1) When a recipient fails to provide information or take an action requested by the department, the recipient must receive adequate notice as defined under chapter 388-458 WAC for reduction, suspension or termination.

(2) When advance notice is required, assistance continues if the recipient does one of the following before the advance notice period ends:

(a) Takes the requested action; or

(b) Provides adequate information that does not result in reduction, suspension, or termination of assistance.

(3) A recipient will receive an additional adequate notice if the recipient provides the following before the advance notice period ends:

(a) Inadequate information; or

(b) Adequate information which results in reduction, suspension, or termination of assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0020 Effective dates for changes. The following rules apply to recipients of all programs unless otherwise specified.

(1) When a change causes a cash assistance recipient to become ineligible or results in a change in grant amount, the effective date of the change is the first day of the next month after the change occurred. However, for the following types of changes, the effective date is:

(a) The date a person who is added to the assistance unit enters the household or is determined eligible, whichever is later;

(b) The date of a change in shelter arrangement which makes the assistance unit eligible for a higher payment standard;

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(c) The first regular monthly issuance when a person changes from one cash assistance program to another;

(d) The first regular monthly issuance after the advance notice period when a grant deduction is imposed to collect an overpayment;

(e) The date of termination when child support or spousal support is increased as specified in WAC 388-422-0030.

(f) In accordance with:

(i) Chapter 388-450 WAC when budgeting income;

(ii) Chapter 388-480 WAC when an assistance unit member is on strike;

(iii) WAC 388-462-0005(2) when pregnant woman receives GA-S and then relinquishes the child for adoption; and

(iv) As specified by the department for changes in law or regulation.

(g) For TANF/SFA, the date a sanctioned WorkFirst participant complies with the requirements of their individual responsibility plan as specified under chapter 388-310 WAC.

(2) Eligibility for medical care services ends at the same time a recipient's general assistance or ADATSA eligibility is terminated.

(3) When a change makes a recipient ineligible or reduces the benefit amount, assistance will continue without change through the advance notice period even when the advance notice is beyond the effective date.

(4) When cash and food assistance benefits are continued beyond the effective date of a reduction or termination of such benefits, an overpayment will be established for the amount the recipient was not eligible to receive.

(5) For prospectively budgeted food assistance households:

(a) The effective date of the change for an increase in benefits is the next allotment after the change is:

(i) Reported when the change is verified within the ten day period; or

(ii) Verified when the assistance unit does not send the requested verification within the ten day period.

(b) The effective date of the change for a decrease in benefits is the first of the next month after the advance notice period expires.

(6) For retrospectively budgeted food assistance households, the effective date of a change reported in the budget month is the first of the payment month.

(7) Eligibility for the newborn medical program ends on the last day of the month the child is no longer living with the mother. Eligibility is redetermined for other medical programs prior to the termination of newborn medical.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-418-0025 Effect of changes on medical. (1) Categorically needy (CN) medical and medically needy (MN) medical is continued until a redetermination of eligibility is made for other medical programs when changes cause a client to become ineligible for:

(a) TANF/SFA; or

(b) SSI; or

(c) GA-H; or

(d) GA-S; or

[Title 388 WAC—p. 553]

(e) CN medical.

(2) When changes cause a refugee cash assistance client to be ineligible, refugee medical assistance can only be continued through the eight-month residence limit, as described in WAC 388-400-0030(6).

(3) TANF/SFA cash recipients are eligible for a medical extension, as described under WAC 388-523-0100, when termination is a result of:

(a) Increased employment income; or

(b) Collection of, or increased collection of, child or spousal support.

(4) Clients who report changes in income or resources during a certification period will have their medical continued until eligibility is redetermined for:

(a) CN or medically needy (MN) for TANF/SFA-related, SSI-related, or refugee-related medical; or

(b) Medically indigent (MI) program.

(5) Changes in income reported by clients during a certification period will not have an affect on medical eligibility for:

(a) The pregnant women's program; or

(b) The children's CN program; or

(c) The children's health program; or

(d) The first six months of the TANF/SFA-related medical extension; or

(e) The newborn medical program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-508-0840, 388-509-0920, 388-509-0960, 388-522-2205 and 388-522-2210.]

WAC 388-418-0030 Notifying a recipient of intent to reduce, suspend or terminate assistance. (1) For cash, medical and food assistance a recipient must be notified ten days in advance of an action to reduce, suspend or terminate assistance. Certain types of circumstances do not require advance notice.

(2) When a ten day advance notice is not required:

(a) For cash assistance and medical, the notice must be mailed or given to the recipient by the date of the action to reduce, suspend or terminate the benefits.

(b) For food assistance, the notice must be mailed or given to the recipient by the date the benefits are received or should have been received.

(3) The ten day advance notice period is not required:

(a) For recipients of cash and food assistance when:

(i) The recipient's whereabouts are unknown and mail was returned by the post office marked no forwarding address;

(ii) The recipient requests termination;

(iii) The department has factual information that the assistance unit has moved to another state or will move to another state before the next benefits are issued; or

(iv) The recipient states in writing that they understand the information they provided will reduce, suspend or terminate their benefits.

(b) For cash and food assistance when the action is based on information provided on a monthly report.

(c) For cash assistance when:

(i) The department has factual information that the recipient or nonrecipient caretaker has died when no other caretaker is available;

(ii) A recipient child is removed from the home under a court order or is voluntarily placed in foster care by the adult caring for the child; or

(iii) A recipient was admitted or committed to an institution which makes them ineligible for benefits.

(d) When a cash assistance recipient's benefits are reduced or terminated because of long-term hospital stay or the recipient is placed in a nursing home.

(e) For food assistance only, when:

(i) The department has factual information that all assistance unit members have died;

(ii) The federal or state government makes mass changes;

(iii) The benefits are reduced because cash assistance is approved;

(iv) An assistance unit member is disqualified for an intentional program violation and the benefits of the remaining members are reduced or terminated because of this disqualification; or

(v) The department reduces the allotment to collect for an overpayment and the assistance unit already received advance notice.

(4) A separate notice is not required:

(a) For cash and food assistance when:

(i) Benefits were approved the recipient was notified of the amount of benefits for each month because the amounts varied.

(ii) The recipient was already notified when a supplemental payment or increased allotment to restore lost benefits would end.

(b) For cash assistance, when the recipient was already notified that an emergent need payment was for one month only.

(5) A client continues to receive the same benefits received prior to a ten-day advance notice of reduction, suspension or termination of benefits (continued benefits) when:

(a) The client requests a fair hearing during this ten-day period; and

(b) For food assistance only, the client's certification period has not expired.

(6) A client receives continued benefits through the end of the month the fair hearing decision is mailed unless:

(a) The client:

(i) States in writing that the assistance unit does not want continued benefits;

(ii) Withdraws the fair hearing request in writing; or

(iii) Abandons the fair hearing request; or

(b) An administrative law judge issues a written order that ends continued benefits prior to the fair hearing.

(7) For food assistance clients, continued benefits end when the certification period expires.

(8) Any continued benefits a client receives pending a fair hearing decision are considered an overpayment when the fair hearing decision agrees with the department's action.

(9) When eligibility for medical care is terminated the client is provided with advance and adequate written notice.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-418-0030, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2205 and 388-525-2570.]

Chapter 388-420 WAC CHEMICAL DEPENDENCY FOOD ASSISTANCE

WAC

388-420-010 Alcohol and drug treatment centers.

WAC 388-420-010 Alcohol and drug treatment centers. (1) Food assistance is only available to a resident of a drug or alcohol treatment center when the treatment center is:

- (a) Administered by a public or private nonprofit agency; and
- (b) Certified by the division of alcohol and substance abuse (DASA).

(2) A resident is considered a one person assistance unit. However if the resident's spouse or child is also living in the treatment center, the spouse or child is included in the resident's assistance unit.

(3) The resident must have a designated employee of the treatment center act as an authorized representative as specified in chapter 388-460 WAC.

(4) The authorized representative receives and uses the food assistance benefits for meals the resident is served in the treatment center.

(5) The authorized representative also has responsibilities as specified in chapter 388-460 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-420-010, filed 7/31/98, effective 9/1/98.]

Chapter 388-422 WAC CHILD SUPPORT

WAC

388-422-0005 Assignment of support rights.
388-422-0010 Cooperation with division of child support.
388-422-0020 Good cause for not cooperating with the division of child support.
388-422-0030 Child support in excess of the TANF grant payment.

WAC 388-422-0005 Assignment of support rights. (1) To receive cash assistance under TANF, SFA, or GA-H, each client must assign to the state of Washington all rights to support for each person for whom the client is applying. This includes the rights to any support which has accrued before assignment is made. If a client fails to assign support rights for each person for whom assistance is requested, then cash assistance will be denied to the entire assistance unit.

(2) To receive medical assistance, each client must assign to the state of Washington all rights to medical support for each person for whom the client is applying. This includes the rights to any medical support which has accrued before assignment is made.

(3) Assignment is made when a client signs the application or accepts the cash or medical assistance.

(4) After assignment is made, a client must send any direct support they receive to the division of child support (DCS).

(1999 Ed.)

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-422-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0560.]

WAC 388-422-0010 Cooperation with division of child support. (1) When applying for or receiving TANF, SFA, GA-H, or Medicaid, the following individuals must cooperate with the DCS in establishing paternity and collecting support as specified in WAC 388-14-201:

(a) All persons for whom benefits are applied for or received; and

(b) The caretaker relative or court-appointed guardian of a child for whom benefits are applied for or received.

(2) For TANF and SFA, if a caretaker relative fails to cooperate with DCS without good cause according to WAC 388-422-0020, the cash grant paid to the assistance unit will be reduced by twenty-five percent of what they would otherwise have received.

(3) For Medicaid, if a caretaker relative fails to cooperate with DCS without good cause according to WAC 388-422-0020, that individual will be denied medical assistance unless they are pregnant.

(4) Cooperation is determined by DCS.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-422-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0560.]

WAC 388-422-0020 Good cause for not cooperating with the division of child support. (1) An individual described under WAC 388-422-0010 is not required to cooperate with DCS if the department finds that cooperation is against the best interest of the child for whom child support is sought. A client has the right to claim good cause for refusing to cooperate and the department must determine if the claim is valid.

(2) Cooperation is against the best interest of the child and cash assistance can be continued when:

(a) The individual's cooperation can reasonably be anticipated to result in serious physical or emotional harm to:

(i) The child; or

(ii) The caretaker relative, if it reduces the caretaker relative's capacity to adequately care for the child; or

(b) Establishing paternity or securing support would be harmful to the child who:

(i) Was conceived as a result of incest or forcible rape; or

(ii) Is the subject of legal adoption proceedings pending before a superior court; or

(iii) Is the subject of ongoing discussions between the parent and a public or licensed child placement agency to decide whether the parent will keep the child or put the child up for adoption. The discussions cannot have gone on for more than three months.

(3) When cash assistance cannot be continued because a client's claim of good cause does not meet the standard in subsection (2) of this section, medical assistance may be able to be continued. The standard for good cause for medical assistance is broader in that good cause can be based solely on the best interests of the:

(a) Child as in subsection (2) of this section; or

(b) Person who is being asked to cooperate.

(4) A client has twenty days from the date good cause is claimed to provide information and evidence to support the claim, unless it cannot be obtained within such time.

(5) A client has the right to:

(a) Be informed of their right to claim good cause for refusing to cooperate;

(b) Receive a determination of their good cause claim within thirty days of the date the claim is made, as long as the necessary information and evidence was provided to the department within twenty days;

(c) Receive assistance without delay while their good cause claim is pending a determination, if they have provided supportive evidence and information;

(d) Receive information on their right to ask for a fair hearing if the department denies the claim of good cause; and

(6) Approved good cause claims will be reviewed at least every six months to determine if good cause continues to exist.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-422-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0570 and 388-505-0560.]

WAC 388-422-0030 Child support in excess of the TANF grant payment. A TANF recipient is ineligible when current child support collected by the division of child support exceeds the TANF grant payment for two-consecutive months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-422-0030, filed 7/31/98, effective 9/1/98.]

Chapter 388-424 WAC

CITIZENSHIP/ALIEN STATUS

WAC

388-424-0005	Citizenship and alien status—General eligibility conditions.
388-424-0010	Alien status—Eligibility requirements for the temporary assistance for needy families program and medical benefits.
388-424-0015	Citizenship and alien status—Eligibility requirements for the state family assistance program.
388-424-0020	Alien status and eligibility requirements for the federal food stamp program.
388-424-0025	Citizenship and alien status—Eligibility requirements for the food assistance program for legal immigrants.

WAC 388-424-0005 Citizenship and alien status—General eligibility conditions. (1) To receive benefits for temporary assistance for needy families (TANF), Medicaid, and federal food stamps, persons must be:

- (a) U.S. citizens;
- (b) U.S. nationals; or

(c) Qualified aliens who meet the additional conditions described in WAC 388-424-0010 relative to TANF and Medicaid and WAC 388-424-0020 relative to federal food stamps.

(2) Qualified aliens are aliens:

- (a) Who are lawful permanent residents under the Immigration and Nationality Act (INA);
- (b) Who are granted asylum under section 208 of the INA;

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(c) Who are paroled into the U.S. under section 212 (d)(5) of the INA for at least one year;

(d) Who are admitted to the U.S. as refugees under section 207 of the INA;

(e) Who are aliens whose deportation is being withheld under section 243(h) of the INA;

(f) Who are granted conditional entry into the U.S. under section 203 (a)(7) of the INA as in effect prior to April 1, 1980;

(g) Who are Cuban and Haitian entrants as defined in section (501)(e) of the Refugee Education Assistance Act of 1980; or

(h) Who are victims of domestic violence, or whose children are victims of domestic violence, when:

(i) The domestic violence is committed in the U.S. by the alien's spouse, parent, or a member of the spouse or parent's family residing in the same household as the alien; and

(ii) In situations where the children are the victims of domestic violence, the alien did not actively participate in the violence against his or her own children; and

(iii) The alien no longer resides with the person who committed the domestic violence; and

(iv) There is a substantial connection between the domestic violence and the need for public assistance benefits; and

(v) The alien has an application with the Immigration and Naturalization Service (INS) either approved or pending for:

(A) Legal immigration status under sections 204 (a)(1)(A)(iii)(I) and 204 (a)(1)(A)(iv) of the INA; or

(B) Suspension of deportation or cancellation of removal under section 244 (a)(3) of the INA.

(3) To receive benefits under the general assistance and ADATSA programs, persons must be:

- (a) U.S. citizens;
- (b) U.S. nationals;
- (c) Qualified aliens; or
- (d) Aliens permanently residing in the U.S. under color of law (PRUCOL).

(4) Aliens are considered to be PRUCOL when they are permanently residing in the U.S., who do not meet the definition of a qualified alien as defined in subsection (2) of this section, and:

- (a) The INS knows they are residing in the U.S., and
- (b) The INS is not likely to enforce their departure.

(5) During the application process, one of the following persons must indicate on the application for benefits whether each household member is a U.S. citizen or qualified alien:

- (a) An adult applicant in the household; or
- (b) The person applying for benefits when there are no adults in the household.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520, 388-518-1805 and 388-510-1020.]

WAC 388-424-0010 Alien status—Eligibility requirements for the temporary assistance for needy families program and medical benefits. (1) Qualified aliens who were residing in the U.S. before August 22, 1996

can receive temporary assistance for needy families (TANF) and Medicaid benefits.

(2) Qualified aliens who first physically enter the U.S. on or after August 22, 1996 cannot receive TANF or Medicaid for five years after their date of entry, unless they are:

(a) Refugees admitted to the U.S. under section 207 of the Immigration and Nationality Act (INA);

(b) Aliens granted asylum under section 208 of the INA;

(c) Aliens whose deportation is being withheld under section 243(h) of the INA;

(d) Cuban and Haitian entrants as defined in section (501)(e) of the Refugee Education Assistance Act of 1980;

(e) Amerasians admitted to the U.S. under section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as amended); or

(f) Lawful permanent residents who are:

(i) On active duty in the U.S. military, other than active duty for training;

(ii) Honorably discharged U.S. veterans;

(iii) Veterans of the military forces of the Philippines who served prior to July 1, 1946, as described in Title 38, section 107 of the U.S. code;

(iv) Hmong and Highland Lao veterans who served in the military on behalf of the U.S. Government during the Vietnam conflict; or

(v) The spouse or unmarried dependent children of a person described in subsections (i) through (iv).

(3) An alien who would qualify for Medicaid benefits, but is ineligible solely because of his or her alien status, can receive medical coverage as follows:

(a) State-funded categorically needy (CN) scope of care for

(i) Pregnant women, as specified in WAC 388-462-0015;

(ii) Children, through the children's health program, as specified in WAC 388-505-0210;

(iii) Persons eligible for or receiving cash assistance under the state family assistance program (SFA); and

(iv) Persons who were lawfully residing in the U.S. prior to August 22, 1996, including PRUCOL aliens as defined in WAC 388-424-0005(4).

(b) Alien emergency medical services as specified in WAC 388-438-0110.

(4) A person's alien status is not used to determine eligibility for the medically indigent program as described in WAC 388-438-0100.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0520 and 388-518-1805.]

WAC 388-424-0015 Citizenship and alien status—

Eligibility requirements for the state family assistance program. (1) Aliens who first physically enter the U.S. on or after August 22, 1996 can receive SFA only after an adult caretaker relative in the assistance unit has resided in Washington state for twelve consecutive months. This requirement:

(a) Applies to an alien only once during his or her lifetime; and

(b) Does not apply to North American Indians born in Canada who are allowed to cross the U.S./Canadian border freely under section 289 of the INA.

(2) To receive SFA benefits, persons must be:

(a) Qualified aliens who are not eligible for TANF benefits because of the five-year period of ineligibility described in WAC 388-424-0010(2); or

(b) Aliens who are permanently residing in the U.S. under color of law (PRUCOL) as defined in WAC 388-424-0005(4).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

WAC 388-424-0020 Alien status and eligibility requirements for the federal food stamp program. (1) For federal food stamps, an alien must meet one of the conditions in column 1 and one of the conditions in column 2.

Column 1

Refugee

Asylee

Deportation withheld

Cuban or Haitian entrant

Aliens lawfully admitted for permanent residence
(immigrants)

Parolee for at least one year

Conditional Entrant

Battered spouse, battered child, or parent or child of a
battered person as defined in WAC 388-424-0005

Column 2

The following noncitizens are only eligible for seven years after admitted or granted status:

Refugee/Amerasian/Asylee

Deportation withheld/Cuban or Haitian entrant

(The above noncitizens may be eligible even if they become immigrants within the seven-year period.)

There is no time limit for the following noncitizens:

1. Permanent resident aliens with forty Social Security Administration (SSA) work quarters.
2. Honorably discharged veterans, active duty military (other than training), spouse, and unmarried dependent children.
3. Lawfully in U.S. on August 22, 1996 and:
 - a. Now under eighteen, or
 - b. Disabled or blind, or
 - c. Sixty-five or older on August 22, 1996.

(2) In addition to the above noncitizens, the following, legally residing in the U.S., are eligible for federal food stamps.

(a) Hmong or Highland Laotian tribe members (and spouse and dependent children) when tribe rendered assistance to the U.S. during the Vietnam era.

(b) Canadian born American Indians who are fifty percent American Indian blood.

(c) American Indians who are noncitizens and members of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act.

(3) Lawful permanent residents can receive credit for SSA work quarters by:

(a) Earning enough money to qualify for work quarters; or

(b) Getting credit for quarters earned by a parent or step-parent while the alien is under eighteen; or

(c) Getting credit for quarters earned by a spouse during their marriage if the alien remains married to the spouse or the spouse is deceased.

(4) Lawful permanent residents cannot receive credit for a SSA work quarter after January 1, 1997 if receiving TANF, nonemergency Medicaid, or food stamp benefits during that quarter.

[Statutory Authority: RCW 74.04.510, S. 1150, the Agricultural Research, Extension, and Education Reform Act of 1998. 99-01-058, § 388-424-0020, filed 12/11/98, effective 1/11/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

WAC 388-424-0025 Citizenship and alien status—Eligibility requirements for the food assistance program for legal immigrants. To receive benefits under the food assistance program for legal immigrants (FAP), a person must be:

(1) A qualified alien who cannot receive federal food stamps because of the eligibility restrictions described in WAC 388-424-0020; or

(2) An alien who is:

(a) Allowed to enter the U.S. for permanent residence by permission of the U.S. Attorney General under section 249 of the Immigration and Nationality Act (INA);

(b) Admitted for temporary residence under section 245A of the INA and is aged, blind, or disabled as described in Title XVI of the Social Security Act;

(c) Granted temporary resident status by the Immigration and Naturalization Service (INS) as a special agricultural worker under section 210 of the INA;

(d) Granted family unity status by the INS and the alien's spouse or parent is eligible to participate in FAP or the federal food stamp program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-424-0025, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1805.]

Chapter 388-426 WAC CLIENT COMPLAINTS

WAC

388-426-0005 Client complaints.

[Title 388 WAC—p. 558]

WAC 388-426-0005 Client complaints. (1) Clients who believe they have been discriminated against by the department for reason of age, race, color, sex, disability, religious creed, political beliefs or national origin, have the right to file a written complaint.

(a) Clients wishing to file a complaint of discrimination regarding food stamp benefits must send complaints to food and nutrition services (FNS); and

(b) Clients of all other programs must send discrimination complaints to the state office of equal opportunity (OEO), Olympia WA.

(2) Clients with a complaint about a department decision or action have the right to present their complaint, in writing, to a supervisor. Within ten days of the receipt of the complaint:

(a) A decision will be made on the client's complaint; and

(b) The client will be sent written notice of the decision, including information about the right to further review by the local office administrator.

(3) Clients not satisfied with the decision of a supervisor have the right to present a written complaint to the local office administrator. Within ten days of the receipt of the complaint:

(a) A decision will be made on the complaint, and

(b) The client will be sent written notice of the decision.

(4) Written notice of the administrator's decision concludes the complaint procedure.

(5) The filing of a written complaint does not prevent a client from requesting a fair hearing under chapter 388-08 WAC.

(6) Clients have the right to speak to a worker's supervisor or have a decision or action reviewed by the supervisor, whether or not a formal complaint has been filed.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-426-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-428 WAC CONFIDENTIALITY

WAC

388-428-0010 Request for address disclosure by a parent when a child is living with a nonparental caretaker.

WAC 388-428-0010 Request for address disclosure by a parent when a child is living with a nonparental caretaker. (1) When TANF or SFA has been approved for a child who is living with a nonparental caretaker, the address and location of the child may be released to the child's parent when:

(a) The parent has legal custody of the child or is allowed visitation rights or residential time with the child under a court order; and

(b) No court order restricts or limits the parent's right to contact or visit the child or the child's caretaker by imposing conditions to protect the child or the caretaker from harm;

(c) The department has not found that the caretaker has good cause for refusing to cooperate in child support enforcement activities related to the parent's support obligation; and

(d) There is no substantiated claim or pending investigation involving abuse or neglect of any child by the parent;

(e) There are no pending proceedings as listed in subsections (1)(b) through (d).

(2) A parent may request the child's address and location:

(a) In person, with satisfactory evidence of identity, at the community services office where the child's record is being maintained;

(b) Through an attorney; or

(c) If residing outside the state of Washington, by submitting a notarized request.

(3) If the request for the child's address and location is based on a court order granting the parent legal custody, visitation rights or residential time, the parent must also submit:

(a) A copy of the court order; and

(b) A sworn statement that the order has not been modified.

(4) Prior to release of the child's address and location, the child's caretaker will be notified that:

(a) The child's parent has requested the information; and

(b) The information will be released within thirty days from the date of the notice unless the caretaker:

(i) Provides proof of a current investigation or pending court case involving the abuse or neglect of any child by the parent;

(ii) Provides a copy of a court order which prevents disclosure of the address or restricts the parent's right to contact or visit the caretaker or the child by imposing conditions to protect the caretaker or child from harm;

(iii) Requests a fair hearing which results in a decision that disclosure must be denied because of the existence of one or more of the conditions in subsection (1) of this section.

(5) A parent's request for disclosure of a child's address and location will be responded to within thirty-five days. The response will notify the parent:

(a) Of the child's address and location if the information may be disclosed;

(b) The reasons for denying the request if the information may not be disclosed; or

(c) That a decision has not been made because the child's caretaker:

(i) Has requested a hearing and a final hearing decision has not been entered; or

(ii) Is claiming good cause for refusing to cooperate in child support enforcement activities related to the parent's support obligation and a final decision has not been made on the caretaker's claim.

(d) When the decision has not been made because of a pending fair hearing decision or good cause claim determination, the parent will be notified of the decision within ten days of the hearing decision or good cause determination.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-428-0010, filed 7/31/98, effective 9/1/98.]

388-430-0015 Deprivation due to incapacity.
388-430-0020 Deprivation due to unemployment.
388-430-0025 Work quarters.

WAC 388-430-0001 Establishing deprivation. (1) For TANF/SFA, a child must be deprived of the support and care of one or both parents due to one of the following reasons:

- (a) Death;
- (b) Absence;
- (c) Incapacity; or
- (d) Unemployment.

(2) Deprivation of a child due to death or absence ceases when the remaining parent marries.

(3) Deprivation of a child due to incapacity or unemployment does not apply when only one of the child's parents is living in the home.

(4) Deprivation for each child is established separately when children within a family have different parents.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-430-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-430-0005 Deprivation due to absence. (1) A child is deprived due to the absence of a parent when a parent resides outside the child's home and does not provide to the child one of the following elements of parental functions:

- (a) Routine visits to the child;
- (b) Maintaining support and in-kind contributions at least equal to the child's prorated share of the monthly need standard for the child's assistance unit as listed in WAC 388-478-0015;
- (c) Performing or assisting with continuous day-to-day physical care of the child; or
- (d) Participating in and being responsible for day-to-day guidance of the child's physical, emotional, and intellectual development.

(2) Deprivation due to absence includes a two parent family when a parent convicted of an offense is permitted to live in the family home but is required by the court to perform unpaid work or unpaid community service. The needs of the convicted parent are not considered in the determination of eligibility or benefit payment to the assistance unit.

(3) Deprivation due to absence does not exist if the reason for the parent's absence from the child's home is due solely to serving on active duty in the United States military services.

(4) For applicants, deprivation due to absence does not exist if the parent is expected to return to the home within the first benefit month. Payment may be made for the first benefit month, but not the second month, if the parent will return within the second month.

(5) For recipients after the first two months of benefits, deprivation due to absence ceases to exist at the end of the month in which the parent returns to the home.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-430-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-430 WAC

DEPRIVATION

WAC

388-430-0001 Establishing deprivation.

388-430-0005 Deprivation due to absence.

388-430-0010 Definition of maintenance, physical care and guidance.

(1999 Ed.)

WAC 388-430-0010 Definition of maintenance, physical care and guidance. (1) Maintenance means the financial support and in-kind contributions paid directly to the child's household, including:

- (a) Child support;

- (b) Food;
- (c) Clothing; and
- (d) Other necessities.

(2) Physical care means continuous care of the child on a day-to-day basis by performing tasks, depending on the age of the child, required in the child's daily life including, but not limited to:

- (a) Providing clean clothing and dressing the child;
- (b) Preparing meals and feeding;
- (c) Supervising bedtime; and
- (d) Assisting with other personal care needs.

(3) Guidance means day-to-day parental participation in, and responsibility for, the child's physical, emotional, and intellectual development including, but not limited to:

- (a) Accompanying the child to doctor visits;
- (b) Attending school conferences;
- (c) Disciplining; and
- (d) Participating in decisions concerning the child's well-being and extracurricular activities.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-430-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-430-0015 Deprivation due to incapacity. A child is deprived due to the incapacity of a parent when the child's parent meets the conditions in WAC 388-448-0005.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-430-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-430-0020 Deprivation due to unemployment. (1) Deprivation due to the unemployment of a parent requires that a qualifying parent be established. The qualifying parent is the parent who has earned the most income within the twenty-four month period immediately preceding the month of the application for benefits.

(2) Once determined, the qualifying parent continues as the qualifying parent throughout the time the family remains on cash assistance as a result of that application. The qualifying parent can be changed when an error was made in the initial designation.

(3) For applicants, a child is deprived due to the unemployment of a parent when the qualifying parent meets all of the following conditions:

- (a) Is not employed, or is employed less than one hundred hours per month;
- (b) Has been in the above status for at least thirty days, and during this time has not refused a bona fide offer of employment or training for employment, nor voluntarily left a job without good cause; and
- (c) Has not refused to apply for or accept unemployment compensation benefits; and
- (d) Meets one of the following requirements:

(i) At least six calendar quarters of work within thirteen consecutive quarters. The thirteen consecutive calendar quarters must be within a maximum period of seventeen quarters with quarter number one containing the month of application; or

(ii) Received or was eligible for unemployment compensation benefits within one year of the date of application for assistance.

(4) For recipients, the child remains deprived due to the unemployment of a parent even when the qualifying parent is working over one hundred hours within any month, or with continuous employment.

(5) For recipients, cash assistance may be terminated due to earnings by the qualifying parent in excess of the payment standard. If that employment ends within thirty days of the termination and the household reapplies, the qualifying parent does not need to meet the thirty-day unemployed applicant rule.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-430-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-430-0025 Work quarters. The qualifying parent meets a quarter of work when the parent has:

- (1) Earned or received earned income of fifty dollars or more in a calendar quarter;
- (2) Participated in a department sponsored program of education, training or employment services during a calendar quarter; or
- (3) Earned a quarter of coverage under Social Security Administration criteria.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-430-0025, filed 7/31/98, effective 9/1/98.]

Chapter 388-434 WAC

ELIGIBILITY REVIEWS AND RECERTIFICATIONS

WAC

388-434-0005	Eligibility reviews for cash and medical assistance.
388-434-0010	Recertification for food assistance.

WAC 388-434-0005 Eligibility reviews for cash and medical assistance. (1) Clients receiving cash assistance are required to have eligibility redetermined at least once every twelve months. The redetermination will be based on information provided on a form designated by the department. A family needs to complete only one form.

(2) A client's redetermination may be the scheduled review or initiated before the scheduled review when there are a number of eligibility changes to be reviewed. The redetermination includes:

- (a) A review of each eligibility factor; and
- (b) An evaluation of any change occurring since eligibility was established or last reviewed.

(3) For clients not receiving cash assistance, an eligibility redetermination date will be established in advance. For programs which require a fixed beginning and ending date, eligibility redetermination will be initiated prior to the end of coverage.

(4) Clients receiving assistance will be responsible for completing and responding to the eligibility redetermination request and attending an interview if required under WAC 388-452-0005.

(5) Clients who do not respond to a notice of redetermination will be considered to be withdrawing their request for continuing assistance. Termination of medical assistance will occur if there is insufficient information to redetermine medical program eligibility.

(6) Clients will receive a notice when the cash and food assistance is suspended, terminated, or a benefit error is discovered during the review as specified under chapter 388-458 WAC.

(7) Clients who become ineligible for cash assistance continue to receive the same medical coverage until a redetermination for other medical programs is completed.

(8) Clients not requesting a continuation of cash assistance have a right to be considered for other medical program eligibility.

(9) Clients receiving CN medical only remain eligible until a redetermination of eligibility for other medical programs is completed.

(10) Recipients who are assessed as needing necessary supplemental accommodation (NSA) services will be assisted in complying with the requirements of this section as specified under WAC 388-200-1300.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-434-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2230.]

WAC 388-434-0010 Recertification for food assistance. (1) A household reapplies timely when the department receives the application by:

(a) The fifteenth day of the last month of certification; or

(b) The fifteenth day after the household receives a notice of certification when the household's certification period is two months or less.

(2) A household completes the reapplication process when it:

(a) Submits a timely reapplication;

(b) Completes an interview; and

(c) Submits requested verification.

(3) A household receives uninterrupted benefits when the household completes the reapplication process timely. Uninterrupted benefits mean the household's benefits will continue to be mailed on the same mailing day of the month.

(4) A household that reapplies timely and completes the application process will receive a notice of approval or denial:

(a) By the end of the current certification period; or

(b) By the thirtieth day after the last allotment when the household was certified for one month.

(5) When a household that reapplies late, the reapplication is treated like an initial application and will be approved or denied under WAC 388-406-0035.

(6) See chapter 388-458 WAC for adequate notice and translation requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-434-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-436 WAC EMERGENCY CASH ASSISTANCE

WAC

388-436-0001	Additional requirement for emergent needs (AREN).
388-436-0005	AREN good cause.
388-436-0010	Winterization.
388-436-0015	Consolidated emergency assistance program (CEAP).
388-436-0020	CEAP assistance unit composition.
388-436-0025	Eligibility conditions for CEAP—Job refusal.

(1999 Ed.)

388-436-0030	Eligibility conditions for CEAP—Other possible resources.
388-436-0035	Income and resources for CEAP.
388-436-0040	Excluded income and resources for CEAP.
388-436-0045	Income deductions for CEAP.
388-436-0050	Determining financial need and benefit amount for CEAP.

WAC 388-436-0001 Additional requirement for emergent needs (AREN). (1) Clients eligible for temporary assistance for needy families (TANF), state family assistance (SFA) and refugee cash assistance (RCA) may request additional cash assistance when they do not have funds available to meet the following emergency situations:

(a) To prevent eviction or foreclosure when the household has received a formal written notice of the eviction, notice to pay or vacate, or foreclosure;

(b) To secure new housing when:

(i) An eviction or foreclosure is not preventable;

(ii) It would cost less to obtain new housing than to prevent the eviction;

(iii) The dwelling puts the household's health or safety in danger and the landlord fails or refuses to correct the condition within the time allowed by law; or

(iv) Moving is necessary to escape an abusive spouse.

(c) To prevent a utility shutoff when the household has received a disconnect notice;

(d) To obtain necessary fuel for heating or cooking when the household has no fuel;

(e) To correct a sudden malfunction resulting in the loss of heat, water, electricity or cooking facilities. The household must be legally responsible for the repairs or replacement with no other alternative;

(f) To purchase food when no other resource is available; or

(g) To help the household obtain housing and necessary clothing in the event of a declared natural disaster when funds are not available through a disaster relief program.

(2) The additional cash payment is issued for the lower of:

(a) The amount necessary to prevent or relieve the emergency; or

(b) The TANF payment standard for an assistance unit of that family's size with an obligation to pay a shelter cost.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0005 AREN good cause. (1) Clients requesting an additional cash benefit must show good reason why funds received or expected to be received during the month of request are not available to meet the emergency.

(2) Clients in the following situations have good reason for the funds not being available and resulting in an emergency:

(a) Cash from the grant has been stolen;

(b) The funds were used for necessities such as:

(i) Medical bills;

(ii) Dental care needed to obtain employment or because of pain;

(iii) Escape from abuse;

(iv) Paying for child care in an emergency;

(v) Temporary extra costs were needed for housing, food or clothing provided the action was reasonable. An expenditure is considered reasonable when:

(A) The expenditure is less than the amount specified in WAC 388-436-0050; or

(B) The specific circumstances and need for the expenditure is judged reasonable by the department.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0010 Winterization. (1) Clients eligible for cash assistance under TANF/SFA may be eligible for additional cash benefits for the purpose of winterizing their home.

(2) Clients must meet all of the following conditions:

(a) The clients must own or be purchasing their home;

(b) The primary reason for the repairs is to minimize heat loss or to increase the efficiency of the home heating system;

(c) The repairs are necessary in order to make the home livable in the winter;

(d) Without the repairs, the clients would have to move to rental housing; and

(e) The cost of rental housing for two years would be more than the costs of remaining in their home, including the costs of the repairs.

(3) Clients can receive funds from this program only once.

(4) Payments under this program are made by vendor payment after the repairs have been completed.

(5) The maximum payment for winterizing a home is five hundred dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0015 Consolidated emergency assistance program (CEAP). (1) CEAP is available to the following persons:

(a) A pregnant woman in any stage of pregnancy; or

(b) Families with dependent children.

(2) Applicants must be residents of Washington state as defined in WAC 388-468-0010.

(3) Applicants must demonstrate a financial need for emergency funds for one or more of the following basic requirements:

(a) Food;

(b) Shelter;

(c) Clothing;

(d) Minor medical care;

(e) Utilities;

(f) Household maintenance supplies;

(g) Necessary clothing or transportation costs to accept or retain a job; or

(h) Transportation for a minor, not in foster care, to a home where care will be provided by family members or approved caretakers.

(4) Payment under this program is limited to not more than thirty consecutive days within a period of twelve consecutive months.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0020 CEAP assistance unit composition. (1) To be eligible for CEAP, a child must be living with:

(a) A parent or a relative of specified degree as defined under WAC 388-454-0010; or

(b) Has lived with such a relative within six months of the request for assistance.

(2) The following persons living in the household must be included as members of the CEAP assistance unit:

(a) All full, half, or adopted siblings under eighteen years of age, including a minor parent; and

(b) The parent, adoptive parent, or stepparent living with the child or children.

(3) The following persons living in the household do not have to be included but may be included as members at the option of the applicant:

(a) One caretaker relative of specified degree when the child's parent does not live in the home;

(b) Stepbrothers or stepsisters to all children in the assistance unit.

(4) The following persons may make up a CEAP assistance unit without including others living in the home:

(a) The child of a parent who is a minor when the minor parent is not eligible due to the income and resources of his/her parents; or

(b) A pregnant woman when no other child is in the home.

(5) The following persons living in the household are not included as members of the CEAP assistance unit:

(a) A household member receiving Supplemental Security Income (SSI);

(b) A household member ineligible due to reasons stated in WAC 388-436-0025 and 388-436-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0025 Eligibility conditions for CEAP—Job refusal. (1) Within thirty days of the date of application, applicants for CEAP cannot have refused without good cause:

(a) A bona fide job offer; or

(b) Training for employment.

(2) Applicants have good cause for refusal when the applicant:

(a) Can not perform the work satisfactorily because of a physical, mental, or emotional inability;

(b) Is not able to get to and from the job without undue cost or hardship;

(c) Would be forced to perform hazardous work;

(d) Would be working for less than minimum wage or the wages are not customary for that type of work;

(e) Is offered the job only because of a labor dispute; or

(f) Is not able to obtain necessary child care.

(3) An applicant who cannot demonstrate good cause for refusing a job offer makes the entire assistance unit ineligible for CEAP:

(a) For thirty days from the date of refusal; or

(b) Until the applicant accepts employment, whichever comes first.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0030 Eligibility conditions for CEAP—Other possible resources. (1) As a condition of eligibility for CEAP, applicants must take all necessary steps to establish eligibility for the following programs:

- (a) Temporary assistance for needy families (TANF);
- (b) State family assistance (SFA);
- (c) Refugee cash assistance (RCA);
- (d) Supplemental security income (SSI);
- (e) Medical assistance for those applicants requesting emergency medical care;
- (f) Food assistance for those applicants declaring an emergency food need; and
- (g) Unemployment compensation, if the applicant is potentially eligible.

(2) CEAP applicants under a grant penalty for failure to comply with program requirements of TANF/SFA, Work-First under chapter 388-310 WAC, refugee cash assistance, general assistance or SSI are treated as follows:

(a) All members are ineligible and the CEAP application is denied if compliance could have prevented the need for emergency assistance.

(b) Only the member responsible for the grant penalty is ineligible for CEAP if the compliance could not have prevented the need for emergency assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0035 Income and resources for CEAP. (1) Estimated income, resources and circumstances of the following persons are used in determining need and payment for CEAP:

(a) All persons included as members of the CEAP assistance unit;

(b) If living in the home, the spouses and minor brothers and sisters of persons included as members of the CEAP assistance unit.

(2) Public assistance payments plus authorized additional requirements received in the calendar month of CEAP application are considered as income.

(3) The value of resources not listed as excluded in WAC 388-436-0040 is considered available to meet the emergent needs of the CEAP assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0040 Excluded income and resources for CEAP. Resources and income listed below will not be considered in determining need or payment for CEAP:

- (1) A home as defined under WAC 388-470-0030;
- (2) One vehicle, running and used regularly by the assistance unit, with an equity value not to exceed one thousand five hundred dollars;
- (3) Household furnishings being used by the assistance unit;
- (4) Personal items being used by members of the assistance unit;

(1999 Ed.)

(5) Tools and equipment being used in the applicant's occupation;

(6) The value of the coupon allotment under the Food Stamp Act of 1977, as amended;

(7) Benefits received under the women, infants and children program (WIC) of the child nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended;

(8) Energy assistance payments;

(9) Grants, loans, or work study to a student under Title IV of the Higher Education Amendments or Bureau of Indian Affairs for attendance costs as identified by the institution;

(10) Income and resources of an SSI recipient;

(11) Livestock when the products are consumed by members of the assistance unit;

(12) All resources and income excluded for the TANF program under WAC 388-450-0015, 388-470-0020, and 388-470-0025 and by federal law.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0045 Income deductions for CEAP. The following deductions are allowed when determining the CEAP assistance unit's net income:

(1) A ninety dollar work expense from each member's earned income;

(2) Actual payments made by a member with earned income for care of a member child up to the following maximums:

Hours Worked Per Month	Each Child Under Two Years	Each Child Two Years Or Older
0 - 40	\$ 50.00	\$ 43.75
41 - 80	100.00	87.50
81 - 120	150.00	131.25
121 or More	200.00	175.00

(3) Verified expenses for members of the assistance unit during the current month as follows:

(a) Medical bills;

(b) Child care paid in an emergency in order to avoid abuse;

(c) Dental care to relieve pain; or

(d) Costs incurred in obtaining employment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-436-0050 Determining financial need and benefit amount for CEAP. (1) To be eligible for CEAP assistance, the assistance unit's nonexcluded income, minus allowable deductions, must be less than ninety percent of the TANF payment standard for households with shelter costs. The net income limit for CEAP assistance units is:

Assistance Unit Members	Net Income Limit
1	\$ 314
2	396
3	491
4	577

Assistance Unit Members	Net Income Limit
5	666
6	756
7	873
8 or more	967

(2) The assistance unit's allowable amount of need is the lesser of:

Need Item:Maximum allowable amount by assistance unit size:

	1	2	3	4	5	6	7	8 or more
Food	\$211	\$268	\$332	\$391	\$450	\$511	\$583	\$645
Shelter	258	325	404	476	548	621	719	795
Clothing	30	38	47	56	64	73	83	94
Minor Medical Care	179	228	282	332	382	432	501	554
Utilities	87	110	136	160	184	210	243	268
Household maintenance	64	81	100	118	136	155	178	197
Job related transportation	349	440	546	642	740	841	971	1075

(3) The assistance unit's CEAP payment is determined by computing the difference between the allowable amount of need, as determined under subsection (2) of this section, and the total of:

(a) The assistance unit's net income, as determined under subsection (1) of this section;

(b) Cash on hand, if not already counted as income; and

(c) The value of other nonexcluded resources available to the assistance unit.

(4) The assistance unit is not eligible for CEAP if the amount of income and resources, as determined in subsection (3) of this section, is equal to or exceeds its allowable amount of need.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-436-0050, filed 7/31/98, effective 9/1/98.]

Chapter 388-437 WAC EMERGENCY ASSISTANCE FOR FOOD STAMPS

WAC

388-437-0001 Disaster food stamp program.

WAC 388-437-0001 Disaster food stamp program.
(1) Assistance units that suffer a loss as a result of a federally declared disaster may receive disaster food stamp benefits.

(2) Food and nutrition services (FNS) must approve use of this program when a disaster is declared.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-437-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-438 WAC EMERGENCY ASSISTANCE FOR MEDICAL NEEDS

WAC

388-438-0100 Medically indigent (MI) program.
388-438-0110 Alien emergency medical.

WAC 388-438-0100 Medically indigent (MI) program.
(1) The medically indigent (MI) program is a state funded medical program limited to coverage for emergency medical services.

[Title 388 WAC—p. 564]

(a) The TANF payment standard, based on assistance unit size, for households with shelter costs as specified under WAC 388-478-0020; or

(b) The assistance unit's actual emergent need, not to exceed maximum allowable amounts, for the following items:

(a) An emergency medical condition is described in WAC 388-500-0005;

(b) The client must have had a qualifying emergency medical condition in the month of application or within the three months immediately preceding the month of application;

(c) A client must have incurred an emergency medical expense requirement (EMER) of two thousand dollars per family over a twelve-month period. Qualifying EMER expenses are:

(i) Emergency hospital services and related physician services in a hospital; and

(ii) Emergency ground or air ambulance transportation to a hospital.

(2) The EMER period:

(a) Begins on the first day of the month of certification for MI; and

(b) Continues through the last day of the following twelve-calendar months.

(3) If a client does not meet the EMER amount within the three month base period, as described in WAC 388-519-0100, the amount incurred can be applied to any other application for MI within twelve-month period described in subsection (2).

(4) A client is limited a singly three-month period of MI eligibility per twelve-month EMER period.

(5) A client in a nursing facility can exceed the three-month MI eligibility limit.

(6) Conditions which require the following services meet the definition of emergency for MI, but the client is exempt from the EMER requirement:

(a) Treatment under the involuntary treatment act (ITA); and

(b) DETOX services; and

(c) Institutional and/or waivered services.

(7) Pregnancy meets the definition of emergency for MI.

A pregnant client must meet the EMER requirements.

(8) Resource rules for the MI program follow the TANF and TANF-related resource rules in chapter 388-470 WAC.

(9) If a client's income and/or resources exceed the standards for this program, as described in WAC 388-478-0070,

the excess must be spent down as described in WAC 388-519-0100, for the client to be eligible for MI.

(10) A client is not eligible for MI if they:

(a) Are eligible for, or receiving, any other cash or medical program; or

(b) Entered the state specifically to obtain medical care; or

(c) Are an inmate of a federal or state prison.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0100, filed 7/31/98, effective 9/1/98. Formerly 388-503-0370, 388-518-1805, 388-518-1810 and 388-518-1850.]

WAC 388-438-0110 Alien emergency medical. An alien who is not eligible for other medical programs, is eligible for emergency medical care and services:

(1) Regardless of their date of arrival in the United States;

(2) Except for citizenship, meets Medicaid eligibility requirements as described in WAC 388-505-0210, 388-505-0220 or WAC 388-505-0110; and

(3) Limited to the necessary treatment of an alien's emergency medical condition as defined in WAC 388-500-0005, except that organ transplants and related medical care services are not covered.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0110, filed 7/31/98, effective 9/1/98.]

Chapter 388-440 WAC EXCEPTION TO RULE

WAC

388-440-0001 Exception to rule.

388-440-0005 Exception to rule—Notification requirement.

WAC 388-440-0001 Exception to rule. (1) The secretary of the department, or designee, authorizes department staff to request an exception to a rule in the Washington Administrative Code (WAC) for individual cases when:

(a) The exception would not contradict a specific provision of federal law or state statute; and

(b) The client's situation differs from the majority; and

(c) It is in the interest of overall economy and the client's welfare; and

(d) It increases opportunities for the client to function effectively; or

(e) A client has an impairment or limitation that significantly interferes with the usual procedures required to determine eligibility and payment.

(2) The secretary or the secretary's designee makes the final decision on all requests for exception to a rule.

(3) Clients have no fair hearing rights as defined under chapter 388-08 WAC regarding exception to rule decisions by department staff.

(4) Clients who do not agree with a decision on an exception to rule may file a complaint according to chapter 388-426 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-440-0001, filed 7/31/98, effective 9/1/98.]

(1999 Ed.)

WAC 388-440-0005 Exception to rule—Notification requirement. (1) Clients are notified in writing within ten days of:

(a) The department staff's decision to file an exception to rule request; and

(b) The department's decision to approve or deny an exception to rule request.

(2) The notice will include the complaint procedures as specified in chapter 388-426 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-440-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-442 WAC FELONS

WAC

388-442-0010 Felons.

WAC 388-442-0010 Felons. (1) A person is not eligible for TANF/SFA, GA and/or food assistance if the person is:

(a) Fleeing to avoid prosecution, custody, or confinement after conviction of a crime, or an attempt to commit a crime which is considered a felony in the place from which they were fleeing; or

(b) Violating a condition of probation or parole as determined by an administrative body or court that has the authority to make this decision.

(2) A person is not eligible for TANF/SFA and/or food assistance if convicted of a felony committed after August 21, 1996 involving possession, use, or distribution of an illegal drug, unless the person:

(a) Was convicted only of possession or use of an illegal drug; and

(b) Was not convicted of a felony for illegal drugs within three years of the latest conviction; and

(c) Was assessed as chemically dependent by a program certified by the division of alcohol and substance abuse (DASA); and

(d) Is taking part in or has completed a rehabilitation plan consisting of chemical dependency treatment and job services.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-442-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-444 WAC FOOD STAMP EMPLOYMENT AND TRAINING

WAC

388-444-0005 The food stamp employment and training (FS E&T) program—General requirements.

388-444-0010 Clients who are required to register for work and must participate in FS E&T.

388-444-0015 Clients who are not required to register for work or participate in FS E&T (exempt clients).

388-444-0020 Clients who must register for work but are not required to participate in FS E&T.

388-444-0025 Payments for FS E&T related expenses.

388-444-0030 Work requirements for persons who are able-bodied adults without dependents (ABAWDS).

388-444-0035 Clients who are exempt from ABAWD provisions.

388-444-0040 Welfare.

388-444-0045 Regaining eligibility for food assistance.

388-444-0050 Good cause for failure to register for work or for not participating in the FS E&T program.

388-444-0055 FS E&T disqualifications.

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388-444-0060	FS E&T—Unsuitable employment.
388-444-0065	Quitting a job.
388-444-0070	Good cause for quitting a job.
388-444-0075	Disqualifications for quitting a job without good cause.

WAC 388-444-0005 The food stamp employment and training (FS E&T) program—General requirements. (1) To receive food assistance some clients must register for work and if required by the department, must participate in the food stamp employment and training (FS E&T) program.

(2) Clients who must register for work and may be required to participate in FS E&T are called nonexempt clients. All other members of the food assistance unit are called exempt clients.

(3) All nonexempt members of the food assistance unit are registered for work by the department, at the first food assistance application and once every twelve months thereafter. A person who enters an existing assistance unit will be registered for work and FS E&T, if not exempt.

(4) Clients must comply with all FS E&T program requirements as provided in subsection (5) of this section. Failure to comply without good cause will disqualify the client from receiving food assistance:

(a) Good cause rules are provided in WAC 388-444-0050; and

(b) Disqualification rules are provided in WAC 388-444-0055.

(5) Nonexempt clients are required to:

(a) Report to DSHS or the service provider and participate as required;

(b) Provide information regarding employment status and availability for work as requested;

(c) Report to an employer when referred by DSHS; and

(d) Accept a bona fide offer of suitable employment.

Unsuitable employment is defined in WAC 388-444-0060.

(6) A nonexempt client will participate in one or more of the following activities:

(a) Job search;

(b) General education development (GED) classes; or

(c) English as a second language (ESL) classes.

(7) A client is not required to participate in FS E&T activities more than one hundred twenty hours in a month. Hours of participation may include a combination of FS E&T activities as described in subsection (6) of this section and hours worked for pay, either cash or in-kind.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0010 Clients who are required to register for work and must participate in FS E&T. The following clients are nonexempt, must register for work and are required to participate in FS E&T:

(1) Age sixteen through fifty-nine with dependents;

(2) Age sixteen or seventeen, not attending secondary school and not the head-of-household;

(3) Age fifty through fifty-nine with no dependents.

(4) Age eighteen to fifty, able-bodied and with no dependents as provided in WAC 388-444-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0015 Clients who are not required to register for work or participate in FS E&T (exempt clients). Clients not required to register for work or to participate in FS E&T are those who are:

(1) Age sixteen or seventeen and not the head-of-household and:

(a) Attending school; or

(b) Enrolled in a program under temporary assistance for needy families (TANF), a program under Job Training Partnership Act (JTPA), a program under section 236 of the Trade Act of 1974, or other state or local employment and training programs at least half time.

(2) Physically or mentally unable to work;

(3) Responsible for the care of a dependent child under six years of age or of an incapacitated person;

(4) Applying for or receiving unemployment compensation (UC);

(5) Participating in an employment and training program under TANF;

(6) Employed or self-employed thirty hours or more per week, or receiving weekly earnings equal to the federal minimum wage multiplied by thirty. This includes migrant and seasonal farm workers under contract or agreement with an employer;

(7) Enrolled as a student as defined in chapter 388-482 WAC, Student status; or

(8) Regularly participating in a drug addiction or alcoholic treatment and rehabilitation program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0020 Clients who must register for work but are not required to participate in FS E&T. The following clients must register for work but are exempt from participation in the FS E&T program:

(1) Participants in a refugee assistance program;

(2) Clients living in an area where the FS E&T program is not provided (exempt area);

(3) Clients who live one hour or more travel distance from available FS E&T services;

(4) Clients who do not have a mailing address or message telephone;

(5) Clients who have a temporary incapacity expected to last sixty days or more; or

(6) Clients who have dependent care needs that exceed the maximum amount payable by the department. The exemption continues until:

(a) A different work activity is available; or

(b) Circumstances change and monthly dependent care costs no longer exceed the reimbursement limit set by the department.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0025 Payments for FS E&T related expenses. (1) Some of a client's actual expenses needed to participate in the FS E&T program may be paid by the department. Allowable expenses are:

(a) Transportation related costs; and

(b) Dependent care costs for each dependent six through twelve years of age.

(2) Dependent care payments are not paid if:

(a) The child is thirteen years of age or older unless the child is:

(i) Physically and/or mentally incapable of self-care; or

(ii) Under court order requiring adult supervision; or

(b) Any member in the food assistance unit provides the dependent care.

(3) Dependent care payments paid by the department cannot be claimed as an expense and used in calculating the dependent care deduction as provided in WAC 388-450-0185.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0030 Work requirements for persons who are able-bodied adults without dependents (ABAWDS). (1) Clients who are age eighteen to fifty and have no dependents must, unless exempt, participate in specific employment and training activities to receive food assistance.

(2) Nonexempt clients who fail to participate are eligible for no more than three months of food assistance in a thirty-six month period.

(3) Except as provided in WAC 388-444-0035, a person is not eligible to receive food assistance for more than three full months in the thirty-six month period beginning January 1, 1997 unless that person:

(a) Works at least twenty hours a week averaged monthly; or

(b) Participates in and complies with the requirements of a work program for twenty hours or more per week; or

(c) Participates in a workfare program as provided in WAC 388-444-0040.

(4) A work program is defined as a program under:

(a) The Job Training Partnership Act (JTPA);

(b) Section 236 of the Trade Act of 1974; or

(c) A state-approved employment and training program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0035 Clients who are exempt from ABAWD provisions. A client is exempt from the ABAWD rules provided in WAC 388-444-0030 when:

(1) Under eighteen or over forty-nine years of age;

(2) Physically or mentally unable to work;

(3) A parent or other member of a household with responsibility for a dependent child under eighteen years of age or an incapacitated person;

(4) A pregnant woman;

(5) Living in an exempt area approved by U.S. Department of Agriculture; or

(6) Otherwise exempt under food stamp employment and training as follows:

(a) Complying with the work requirements of the Work-First program;

(b) Receiving unemployment compensation;

(c) A student enrolled at least half time in any recognized school;

(1999 Ed.)

(d) A regular participant in a chemical dependency treatment program; or

(e) Employed a minimum of thirty hours per week or receiving weekly earnings which equal the minimum hourly rate multiplied by thirty hours.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0040 Workfare. (1) Workfare is a work program available to clients eighteen to fifty years of age who are able to work and have no dependents.

(2) Workfare consists of:

(a) Thirty days of job search activities in the first month beginning with the first day of application or sixteen hours of volunteer work with a public or private nonprofit agency; and

(b) In subsequent months, sixteen hours per month of volunteer work with a public or private nonprofit agency.

(3) A client is not required to perform Workfare and paid work for more than a total of thirty hours a week.

(4) The department pays for a client's actual expenses needed for the client to participate in Workfare. Standards for paying expenses are set by the department.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0045 Regaining eligibility for food assistance. (1) A client who is ineligible for food assistance because that client has exhausted the three-month limit in WAC 388-444-0030, can regain eligibility by:

(a) Working eighty hours or more during a thirty-day period;

(b) Participating in and complying with a work program for eighty hours or more during a thirty-day period; or

(c) Participating in and complying with a workfare program.

(2) A client who regains eligibility for food assistance under subsection (1) of this section is eligible as long as the requirements of subsection (1) of this section are met.

(3) If otherwise eligible, clients who regain eligibility in subsection (1) of this section and then loses employment or stops participating in a work program or in Workfare will receive an additional three-consecutive months of food assistance. The three-month certification is allowed only once in the thirty-six month period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0050 Good cause for failure to register for work or for not participating in the FS E&T program. (1) A nonexempt client may have good cause for refusing or failing to register for work or to participate in the FS E&T program.

(2) Good cause reasons include, but are not limited to:

(a) Illness of the client;

(b) Illness of another household member requiring the help of the client;

(c) A household emergency;

(d) The unavailability of transportation; or

(e) Lack of adequate dependent care for children six through twelve years of age.

[Title 388 WAC—p. 567]

(3) A client who is determined by the department to lack good cause for failing or refusing to participate in FS E&T is disqualified and is not eligible to receive food assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0055 FS E&T disqualifications. (1) A nonexempt client who refuses or fails to comply with the requirements of the FS E&T program without good cause as provided in WAC 388-444-0050, is disqualified and cannot receive food assistance. The disqualified client is an ineligible assistance unit member as provided in WAC 388-450-0140. The remaining members of the assistance unit continue to be eligible for food assistance.

(2) The client is disqualified for the following minimum periods of time and until the client complies with program requirements:

- (a) For the first failure to comply, one month;
- (b) For the second failure to comply, three months; and
- (c) For the third or subsequent failure to comply, six months.

(3) If a client becomes exempt under WAC 388-444-0015, a disqualification ends when the client has served the one, three, or six month disqualification penalty period and if required, is registered for work.

(4) A nonexempt client disqualified under any of the following conditions is also disqualified under FS E&T and cannot receive food assistance:

(a) Under WorkFirst sanction as provided in chapter 388-310 WAC;

(b) Disqualified from receiving unemployment compensation for failure to comply with requirements comparable to FS E&T requirements; or

(c) Sanctioned for failing to comply with work requirements under the refugee cash assistance program as provided in chapter 388-466 WAC.

(5) At the end of a disqualification period, a client may apply to reestablish eligibility.

(6) Each client has a right to a fair hearing as provided in WAC 388-08-413.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0060 FS E&T—Unsuitable employment. Nonexempt clients participating in FS E&T must accept a bona fide offer of suitable employment. Employment is considered unsuitable when:

(1) The wage offered is less than the federal or state minimum wage, whichever is highest;

(2) The job offered is on a piece-rate basis and the average hourly yield expected is less than the federal or state minimum wage, whichever is highest;

(3) The employee, as a condition of employment, is required to join, resign from or is barred from joining any legitimate labor union;

(4) The work offered is at a site subject to strike or lockout at the time of offer unless:

- (a) The strike is enjoined under the Taft-Hartley Act; or

(b) An injunction is issued under section 10 of the Railway Labor Act.

(5) The degree of risk to health and safety is unreasonable;

(6) The client is physically or mentally unable to perform the job as documented by medical evidence or reliable information from other sources;

(7) The employment offered within the first thirty days of registration for FS E&T is not in the client's major field of experience;

(8) The distance from the client's home to the job is unreasonable considering the wage, time and cost of commute:

(a) The job is not suitable when daily commuting time exceeds two hours per day, not including transporting a child to and from child care; and

(b) The job is not suitable when the distance to the job prohibits walking and public or private transportation is not available.

(9) The working hours or nature of the job interferes with the client's religious observances, convictions, or beliefs.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0060, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0065 Quitting a job. (1) A client who quits their most recent job without good cause is not eligible for food assistance if:

(a) The client was working twenty hours or more per week or the job provided weekly earnings equal to the federal minimum wage multiplied by twenty hours; and

(b) The quit occurred within sixty days prior to application for food assistance or any time thereafter;

(c) At the time of quit, the person would have been required to register for work.

(2) A client is not eligible to receive food assistance if the client has participated in a strike against a federal, state or local government and has lost their employment because of such participation.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0065, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0070 Good cause for quitting a job. Unless otherwise specified the following rules apply to all food assistance clients.

(1) Good cause for quitting a job includes the following:

(a) For all food assistance clients, the employment is unsuitable as defined under WAC 388-444-0060;

(b) The client is discriminated against by an employer based on age, race, sex, color, religious belief, national origin, political belief, marital status, or the presence of any sensory, mental, or physical disability or other reasons in RCW 49.60.180;

(c) Work demands or conditions make continued employment unreasonable, such as working without being paid on schedule;

(d) The client accepts other employment or is enrolled at least half time in any recognized school, training program, or institution of higher education;

(e) The client must leave a job because another assistance unit member accepts a job or is enrolled at least half time in any recognized school, training program, or institu-

tion of higher education in another county or similar political subdivision and the assistance unit must move;

(f) The client who is under age sixty and retires as recognized by the employer;

(g) The client accepts a bona fide offer of employment of twenty or more a week or where the weekly earnings are equivalent to the federal minimum wage multiplied by twenty hours. However, because of circumstances beyond the control of the client, the job either does not materialize or results in employment of twenty hours or less a week or weekly earnings of less than the federal minimum wage multiplied by twenty hours;

(h) The client leaves a job in connection with patterns of employment where workers frequently move from one employer to another, such as migrant farm labor or construction work; and

(i) For FS E&T participants, circumstances included under WAC 388-444-0050;

(2) A client who quits the most recent job is eligible for food assistance if the circumstances of the job involve:

(a) Changes in job status resulting from reduced hours of employment while working for the same employer;

(b) Termination of a self-employment enterprise; or

(c) Resignation from a job at the demand of an employer.

(3) The client must verify good cause for quitting. Food assistance is not denied if the client and the department are unable to obtain verification.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0070, filed 7/31/98, effective 9/1/98.]

WAC 388-444-0075 Disqualifications for quitting a job without good cause. (1) If the client quits a job without good cause, the client is disqualified. The client is disqualified for the following minimum periods of time and until the conditions in subsection (2) of this section are met:

(a) For the first quit, one month;

(b) For the second quit, three months; and

(c) For the third or subsequent quit, six months.

(2) The client may re-establish eligibility after the disqualification, if otherwise eligible by:

(a) Getting a new job;

(b) In nonexempt areas, participating in the FS E&T program;

(c) Participating in Workfare as provided in WAC 388-444-0040;

(d) Becoming exempt as provided in WAC 388-444-0015 or WAC 388-444-0020;

(e) Applying for or receiving unemployment compensation; or

(f) Participating in WorkFirst.

(3) If a disqualified client moves from the assistance unit and joins another assistance unit, the client continues to be treated as an ineligible member of the new assistance unit for the remainder of the disqualification period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-444-0075, filed 7/31/98, effective 9/1/98.]

Chapter 388-446 WAC

FRAUD

WAC

388-446-0001	Cash and medical assistance fraud.
388-446-0005	Disqualification period for cash assistance.
388-446-0010	TANF disqualification period for fraud convictions of misrepresenting interstate residence.
388-446-0015	Intentional program violation (IPV) and disqualification hearings for food assistance.
388-446-0020	Food assistance disqualification penalties.

WAC 388-446-0001 Cash and medical assistance fraud. (1) All cash or medical assistance cases in which substantial evidence is found supporting a finding of fraud are referred to the county prosecuting attorney. The prosecuting attorney's office determines which cases are subject to criminal prosecution.

(2) An applicant or recipient is suspected of committing fraud if intentional misstatement or failure to reveal information affecting eligibility results in an overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0001, filed 7/31/98, effective 9/1/98. Formerly WAC 388-501-0140.]

WAC 388-446-0005 Disqualification period for cash assistance. (1) An applicant or recipient who has been convicted of unlawful practices in obtaining cash assistance is disqualified from receiving further cash benefits if:

(a) For TANF/SFA, the conviction was based on actions which occurred on or after May 1, 1997; or

(b) For general assistance, the conviction was based on actions which occurred on or after July 23, 1995.

(2) The disqualification period must be determined by the court and will be:

(a) For a first conviction, no less than six months; and

(b) For a second or subsequent conviction, no less than twelve months.

(3) The disqualification applies only to the person convicted and begins on the date of conviction.

(4) A recipient's cash benefits are terminated following advance or adequate notice requirements as specified in WAC 388-418-0030.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-446-0010 TANF disqualification period for fraud convictions of misrepresenting interstate residence. (1) An applicant or recipient is disqualified from receiving cash benefits under TANF if convicted of fraud by misrepresentation of residence in order to receive assistance from two or more states at the same time from any assistance program funded by the following:

(a) TANF and any other benefit authorized by Title IV-A of the Social Security Act; or

(b) Any benefit authorized by The Food Stamp Act of 1997; or

(c) Any benefit authorized by Title XIX, Medicaid; or

(d) SSI benefits authorized by Title XVI.

(2) The disqualification penalty is applied as follows:

(a) Only to convictions based on actions which occurred on or after May 1, 1997; and

(b) Only to the person convicted of fraud in federal or state court; and

(c) For a disqualification period of ten years or a period determined by the court, whichever is longer.

(3) The disqualification period begins the date the person is convicted of fraud by misrepresentation of residence in order to receive assistance from two or more states at the same time.

(4) The provisions of subsections (1) through (3) of this section do not apply when the President of the United States has granted a pardon for the conduct resulting in the conviction of fraud by misrepresentation of residence. The disregard of the provisions because of a pardon is effective the date the pardon is granted and continues for each month thereafter.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-446-0015 Intentional program violation (IPV) and disqualification hearings for food assistance.

(1) An intentional program violation (IPV) is defined as an act in which a person intentionally:

- (a) Makes a false or misleading statement;
- (b) Misrepresents, conceals or withholds facts; or

(c) Acts in violation of the Food Stamp Act, the food stamp program regulations, or any state statute relating to the use, presentation, transfer, acquisition, receipt, or possession of food stamp coupons or FCAs.

(2) Food assistance clients suspected of committing an (IPV) are subject to referral for an administrative disqualification hearing, if:

(a) The suspected IPV causes an overissuance of four hundred fifty dollars or more; and

(b) The administrative proceedings will not jeopardize criminal proceedings; and

(c) The person resides in Washington state, at the time of the referral; or

(d) The person resides outside Washington state, but is within one hour's reasonable drive to a CSO.

(3) An administrative disqualification hearing (ADH) is a formal hearing to determine if a person committed an IPV. ADHs are governed by the rules found in chapter 388-08 WAC. However, rules in this section are the overriding authority if there is a conflict.

(4) A client who commits one or more IPVs and is suspected of committing another, is referred for an ADH when the act of suspected violation occurred:

(a) After the department mailed the disqualification notice to the client for the most recent IPV; or

(b) After an order was entered in criminal proceedings for the most recent IPV.

(5) A person suspected of IPV is entitled to receive notice of an ADH at least thirty days in advance of the hearing date. The notice is sent by certified mail, or provided to the client by personal service and will contain the following:

- (a) The date, time, and place of the hearing;
- (b) The charges against the individual;
- (c) A summary of the evidence, and how and where the evidence can be examined;

(d) A warning that a decision will be based solely on evidence provided by the department, if the individual fails to appear at the hearing;

(e) A statement that the individual has ten days from the date of the scheduled hearing to show good cause for failure to appear at the hearing and to request rescheduling;

(f) A warning that a determination of IPV will result in a disqualification period; and

(g) A statement that if a telephone hearing is scheduled, the individual can request an in-person hearing by filing a request with the administrative law judge one week or more prior to the date of the hearing.

(6) The person or a representative shall have the right to one continuance of up to thirty days if a request is filed ten days or more prior to the hearing date.

(7) The hearing will be conducted and a decision rendered even if the person or representative fail to appear, unless within ten days from the date of the scheduled hearing:

(a) The person can show good cause for failing to appear; and

(b) The person or representative requests the hearing be re-instituted.

(8) A scheduled telephone hearing may be changed to an in-person hearing if requested one week or more in advance. If requested less than one week in advance the person must show good cause for the requested change.

(9) The ALJ issues a preliminary decision based on evidence presented by the department establishing the person committed and intended to commit an IPV. The department and the client each have the right to request a review of the ALJ's decision by writing to the department's board of appeals as specified in WAC 388-08-464.

(10) A final decision of the disqualification hearing is mailed by the department's board of appeals.

(11) A client's disqualification is not implemented and benefits continue at the current amount when:

(a) The client can show good cause for not attending the hearing within thirty days from the date the disqualification notice was mailed; and

(b) An administrative law judge determines the client had good cause; or

(c) The client files a petition for review to appeal the disqualification

(12) An administrative disqualification hearing and an overissuance hearing can be combined when the cause for both hearings is related. The hearing procedures and notice requirements are the same as for administrative disqualification hearings.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-446-0020 Food assistance disqualification penalties. (1) Disqualification penalties apply only to the person or persons found to have committed an intentional program violation (IPV) as follows:

(a) If the intentional program violation occurred in whole or in part after the household was notified of the following penalties:

- (i) Twelve months for the first violation;

(ii) Twenty-four months for the second violation;
 (iii) Permanently for the third violation.

(b) If the violation ended before the household was notified of the penalties in subsection (1)(a) of this section:

- (i) Six months for the first violation;
- (ii) Twelve months for the second violation;
- (iii) Permanently for the third violation.

(2) The disqualification and penalty period for a person convicted in another state stays in effect until satisfied regardless of where a person moves.

(3) Multiple program violations are considered as one violation when determining the penalty for disqualification when the violations occurred before the department notified the household of the penalties, as described in subsection (1), (4) and (5) of this section.

(4) Disqualification penalties for persons convicted by a federal, state, or local court of trading or receiving food coupons for a controlled substance are:

- (a) Two years for a first conviction; and
- (b) Permanently for a second conviction.

(5) A first conviction by federal, state, or local court permanently disqualifies persons who:

- (a) Trade or receive food coupons for firearms, ammunition, or explosives; or
- (b) Knowingly buy, sell, trade, or present for redemption food coupons totalling five hundred dollars or more in violation of section 15 (b) & (c) of the Food Stamp Act of 1977, as amended.

(6) Persons convicted of providing false identification or residency information to receive multiple coupon benefits are disqualified for ten years.

(7) When a court convicts a person of an IPV, the disqualification penalties specified in subsection (1) through (5) apply as follows;

(a) In addition to any civil or criminal penalties; and
 (b) Within forty-five days of the date of conviction; unless

(c) Contrary to the court order.

(8) Disqualification penalties are applied after notifying the household of the disqualification, the effective date, the amount of benefits the household will receive during the disqualification period and the need to reapply when the certification period expires.

(9) Even though only the individual is disqualified, the food assistance household is responsible for making restitution for the amount of any overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0020, filed 7/31/98, effective 9/1/98.]

Chapter 388-448 WAC INCAPACITY

WAC

388-448-0001 Who is eligible for general assistance-unemployable.
 388-448-0005 The following criteria is used to determine if a child is deprived of parental support due to incapacity.

WAC 388-448-0001 Who is eligible for general assistance-unemployable. To be eligible for benefits under the general assistance-unemployable (GA-U) program a client must be:

(1) Eligible for payments based on Social Security Administration (SSA) disability criteria; or
 (2) Eligible for services from the division of developmental disabilities (DDD); or
 (3) Diagnosed as mentally retarded and the diagnosis is substantiated by a full scale score of seventy or lower on the Wechsler Adult Intelligence Scale (WAIS); or
 (4) Sixty-five years of age or older; or
 (5) Released from inpatient psychiatric treatment and for ninety days following the date of release if:

- (a) Participating in direct outpatient mental health treatment services; and
- (b) The release was not against medical advice; or
- (6) Eligible for long-term care services from aging and adult services administration; or
- (7) For ninety days after release from a medical institution where the person received long-term care services from the aging and adult services administration; or
- (8) Approved by the Progressive Evaluation Process (PEP); or
- (9) Still incapacitated at redetermination because their medical or mental condition has not clearly improved and no error is found in the previous incapacity determination.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-448-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-448-0005 The following criteria is used to determine if a child is deprived of parental support due to incapacity. Deprivation due to incapacity exists when one or both parents in a two parent household:

(1) Is physically and/or mentally impaired to such a degree that their ability to support or care for a child is substantially reduced or eliminated. The incapacity must be supported by medical evidence and be expected to last at least thirty days; or

(2) Is eligible for payments based on SSA disability criteria; or

(3) Has a fifty percent or greater disability rating from the Veteran's Administration.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-448-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-450 WAC INCOME

WAC

388-450-0005	Income—Ownership and availability.
388-450-0010	Liens against potential time-loss compensation.
388-450-0015	Excluded and disregarded income.
388-450-0020	Income exclusions for SSI-related medical.
388-450-0025	Unearned income.
388-450-0030	Earned income definition.
388-450-0035	Educational benefits.
388-450-0040	Native American benefits and payments.
388-450-0045	Income from employment or training programs.
388-450-0050	Income from the community jobs program.
388-450-0055	Assistance from other agencies and organizations.
388-450-0060	Lump sum payments.
388-450-0065	Gifts—Cash and noncash.
388-450-0070	A child's earned income.
388-450-0075	Income from time-loss compensation.
388-450-0080	Self-employment income—General rules.
388-450-0085	Self-employment income—Allowable expenses.
388-450-0090	Self-employment expenses that are not allowed as income deductions.

(ii) Twenty-four months for the second violation;
 (iii) Permanently for the third violation.

(b) If the violation ended before the household was notified of the penalties in subsection (1)(a) of this section:

- (i) Six months for the first violation;
- (ii) Twelve months for the second violation;
- (iii) Permanently for the third violation.

(2) The disqualification and penalty period for a person convicted in another state stays in effect until satisfied regardless of where a person moves.

(3) Multiple program violations are considered as one violation when determining the penalty for disqualification when the violations occurred before the department notified the household of the penalties, as described in subsection (1), (4) and (5) of this section.

(4) Disqualification penalties for persons convicted by a federal, state, or local court of trading or receiving food coupons for a controlled substance are:

- (a) Two years for a first conviction; and
- (b) Permanently for a second conviction.

(5) A first conviction by federal, state, or local court permanently disqualifies persons who:

- (a) Trade or receive food coupons for firearms, ammunition, or explosives; or
- (b) Knowingly buy, sell, trade, or present for redemption food coupons totalling five hundred dollars or more in violation of section 15 (b) & (c) of the Food Stamp Act of 1977, as amended.

(6) Persons convicted of providing false identification or residency information to receive multiple coupon benefits are disqualified for ten years.

(7) When a court convicts a person of an IPV, the disqualification penalties specified in subsection (1) through (5) apply as follows;

(a) In addition to any civil or criminal penalties; and
 (b) Within forty-five days of the date of conviction; unless

(c) Contrary to the court order.

(8) Disqualification penalties are applied after notifying the household of the disqualification, the effective date, the amount of benefits the household will receive during the disqualification period and the need to reapply when the certification period expires.

(9) Even though only the individual is disqualified, the food assistance household is responsible for making restitution for the amount of any overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-446-0020, filed 7/31/98, effective 9/1/98.]

Chapter 388-448 WAC INCAPACITY

WAC

388-448-0001 Who is eligible for general assistance-unemployable.
 388-448-0005 The following criteria is used to determine if a child is deprived of parental support due to incapacity.

WAC 388-448-0001 Who is eligible for general assistance-unemployable. To be eligible for benefits under the general assistance-unemployable (GA-U) program a client must be:

(1) Eligible for payments based on Social Security Administration (SSA) disability criteria; or
 (2) Eligible for services from the division of developmental disabilities (DDD); or
 (3) Diagnosed as mentally retarded and the diagnosis is substantiated by a full scale score of seventy or lower on the Wechsler Adult Intelligence Scale (WAIS); or
 (4) Sixty-five years of age or older; or
 (5) Released from inpatient psychiatric treatment and for ninety days following the date of release if:

- (a) Participating in direct outpatient mental health treatment services; and
- (b) The release was not against medical advice; or
- (6) Eligible for long-term care services from aging and adult services administration; or
- (7) For ninety days after release from a medical institution where the person received long-term care services from the aging and adult services administration; or
- (8) Approved by the Progressive Evaluation Process (PEP); or
- (9) Still incapacitated at redetermination because their medical or mental condition has not clearly improved and no error is found in the previous incapacity determination.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-448-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-448-0005 The following criteria is used to determine if a child is deprived of parental support due to incapacity. Deprivation due to incapacity exists when one or both parents in a two parent household:

(1) Is physically and/or mentally impaired to such a degree that their ability to support or care for a child is substantially reduced or eliminated. The incapacity must be supported by medical evidence and be expected to last at least thirty days; or

(2) Is eligible for payments based on SSA disability criteria; or

(3) Has a fifty percent or greater disability rating from the Veteran's Administration.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-448-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-450 WAC INCOME

WAC

388-450-0005	Income—Ownership and availability.
388-450-0010	Liens against potential time-loss compensation.
388-450-0015	Excluded and disregarded income.
388-450-0020	Income exclusions for SSI-related medical.
388-450-0025	Unearned income.
388-450-0030	Earned income definition.
388-450-0035	Educational benefits.
388-450-0040	Native American benefits and payments.
388-450-0045	Income from employment or training programs.
388-450-0050	Income from the community jobs program.
388-450-0055	Assistance from other agencies and organizations.
388-450-0060	Lump sum payments.
388-450-0065	Gifts—Cash and noncash.
388-450-0070	A child's earned income.
388-450-0075	Income from time-loss compensation.
388-450-0080	Self-employment income—General rules.
388-450-0085	Self-employment income—Allowable expenses.
388-450-0090	Self-employment expenses that are not allowed as income deductions.

388-450-0095	Allocating income—General.
388-450-0100	Allocating income—Definitions.
388-450-0105	Allocating the income of a financially responsible person included in the assistance unit.
388-450-0106	Allocating the income of a financially responsible person included in the assistance unit to household members excluded because of their alien status.
388-450-0110	Allocating the income of a GA-U client to legal dependents.
388-450-0115	Allocating the income of a financially responsible person excluded from the assistance unit.
388-450-0116	Allocating the income of a financially responsible person excluded from the assistance unit because of their alien status.
388-450-0120	Allocating the income of financially responsible parents to a pregnant or parenting minor.
388-450-0125	Allocating the income of the father of the unborn child to a pregnant woman.
388-450-0130	Allocating the income of a nonapplying spouse to a caretaker relative.
388-450-0135	Allocating income of an ineligible spouse to a GA-U client.
388-450-0140	Income of ineligible assistance unit members—Food assistance.
388-450-0145	Income of a person who is not a member of a food assistance unit.
388-450-0150	SSI-related medical income allocation.
388-450-0155	Deeming income—Alien sponsorship.
388-450-0160	Sponsored alien—Food assistance.
388-450-0165	Gross earned income limit for TANF/SFA.
388-450-0170	TANF/SFA earned income incentive and deduction.
388-450-0175	GA-U earned income incentive and deduction.
388-450-0180	Effect of countable income on eligibility and benefit level for cash assistance.
388-450-0185	General information regarding income deductions for food assistance programs.
388-450-0190	Shelter cost income deductions for food assistance.
388-450-0195	Utility allowances for food assistance programs.
388-450-0200	Medical cost income deductions for food assistance.
388-450-0205	Budgeting income deductions for food assistance.
388-450-0210	Countable income for medical programs.
388-450-0215	Prospective budgeting.
388-450-0220	Retrospective budgeting.
388-450-0225	Budgeting income for cash assistance applicants.
388-450-0230	Treatment of income in the month of application for substitute food assistance households.
388-450-0235	Discontinued income.
388-450-0240	Effect of net lump sum payments for cash assistance.
388-450-0245	Suspending benefits.
388-450-0250	Income of a new assistance unit member.

WAC 388-450-0005 Income—Ownership and availability. (1) For TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs:

(a) All available income owned or possessed by a client is considered when determining the client's eligibility and benefit level.

(b) Ownership of income is determined according to applicable state and federal laws pertaining to property ownership and eligibility for assistance programs. For married persons, ownership of separate and community income is determined according to chapter 26.16 RCW.

(c) Income owned by a client is considered available when it is at hand and may be used to meet the client's current need.

(d) When the department determines that a client may be entitled to or have an interest in income which may be used to reduce the client's need for assistance, the client may be denied assistance when the client fails or refuses to make a reasonable effort to make the income available or receive the entitlement.

(i) A client's eligibility is not affected until the income is received as long as the client makes reasonable efforts to make potential income available; and

(ii) A client may choose whether to receive TANF/SFA or Supplemental Security Income (SSI) benefits.

(e) The income of a person who is not a member of a client's assistance unit may be considered available to the client under the rules of this chapter if the person is financially responsible for the client and lives in the home with the client. For medical programs, financial responsibility is described in WAC 388-408-0055.

(f) For medical programs, the income of a financially responsible person, not living in the home is considered available to the extent it is contributed.

(g) Funds deposited into a bank account which is held jointly by a client and another are considered income possessed by and available to the client unless:

(i) The client can show that all or part of the funds belong exclusively to the other account holder and are held or used solely for the benefit of that holder; or

(ii) The funds have been considered by the Social Security Administration (SSA) when determining the other account holder's eligibility for SSI benefits.

(2) For TANF/SFA, RCA, GA and food assistance programs the income of an alien's sponsor is considered available to the alien under the rules of this chapter when determining the alien's eligibility and benefit level.

(3) For SSI-related medical:

(a) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the clients needs for food, clothing and shelter, except as provided in WAC 388-511-1130.

(b) Loans and certain other receipts are not defined as income for SSI-related purposes as described in 20 C.F.R. Sec. 416.1103.

(4) For medical programs, trusts are described in WAC 388-505-0595.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590 and 388-506-0610.]

WAC 388-450-0010 Liens against potential time-loss compensation. This section applies to TANF/SFA, RCA, GA and TANF/SFA-related medical programs.

(1) By accepting public assistance, adult and minor clients assign to the department the right to recover time-loss compensation.

(2) When an assistance unit consists of unmarried parents only, the portion of cash assistance received by the injured parent and the injured parent's natural, adoptive or stepchildren is recoverable by the department.

(3) When a client or client's attorney claims allowable attorney fees and costs incidental to an increased award, the office of financial recovery (OFR) will:

(a) Determine what portion of the award, if any, resulted directly from the attorney's involvement;

(b) Determine the department's proportionate share of attorney fees and costs applicable to the duplicate coverage period; and

(c) Deduct the department's share of cost in subsection (b) of this section from the lien for duplicated assistance; or

(d) Issue the proportionate share refund to the attorney with a copy of the account summary to the client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0015 Excluded and disregarded income. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Excluded income means income that is not counted when determining a client's eligibility and benefit level. Excluded income types are defined by state and federal laws. Types of excluded income include but are not limited to:

(a) Loans, except certain student loans as specified under WAC 388-450-0035.

(b) Federal earned income tax credit (EITC) payments;

(c) Title IV-E, state and or local foster care maintenance payments;

(d) Energy assistance payments;

(e) Educational assistance as specified in WAC 388-450-0035;

(f) Native American benefits and payments as specified in WAC 388-450-0040;

(g) Income from employment and training programs as specified in WAC 388-450-0045; and

(h) Any amount withheld from a client's benefit to repay an overpayment by the source agency. For food assistance, this exclusion does not apply when the amount is withheld to recoup an intentional noncompliance overpayment from a federal, state, or local means tested program.

(i) Child support payments received by TANF/SFA recipients which have been assigned to the department as a condition of receiving assistance.

(2) For food assistance programs, the following income types are excluded:

(a) Emergency additional requirements authorized to TANF/SFA and RCA clients under WAC 388-436-0001 and paid directly to a third party;

(b) Cash donations based on need received directly by the household if the donations are:

(i) Made by one or more private, nonprofit, charitable organizations; and

(ii) Do not exceed three hundred dollars in any federal fiscal year quarter.

(c) Infrequent or irregular income, received during a three-month period by a prospectively budgeted assistance unit, that:

(i) Cannot be reasonably anticipated as available; and

(ii) Does not exceed thirty dollars for all household members.

(3) All income that is not excluded is considered to be part of an assistance unit's gross income. Gross income is used to determine an assistance unit's eligibility as follows:

(a) For TANF/SFA, RCA, GA-S, and GA-H, the assistance unit is ineligible if its gross income exceeds 185 percent of the need standard as specified in WAC 388-478-0015; and

(b) For certain food assistance households, the assistance unit's gross income cannot exceed one hundred thirty percent of the federal poverty level for the forty-eight contiguous states as specified in WAC 388-478-0060.

(4) Disregarded income means income that is not excluded when determining an assistance unit's gross income

but which is disregarded when determining an assistance unit's countable income. Types of disregarded income are defined by state and federal laws. Disregarded income includes but is not limited to:

(a) Earned income incentives and disregards for cash assistance; and

(b) Food assistance income deductions.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

WAC 388-450-0020 Income exclusions for SSI-related medical. This section describes the types of income which are excluded or not counted when determining how much of a client's income is compared to the income standards in WAC 388-478-0065 through 388-478-0085 to determine eligibility.

(1) The first twenty dollars per month of a client's earned or unearned income, which is not otherwise excluded in this section, is excluded. This exclusion:

(a) Can only be allowed once for a husband and wife; and

(b) Does not apply to income paid on the basis of an eligible person's needs, which is funded totally or partially by the federal government or a private agency.

(2) The first sixty-five dollars per month of a client's earned income, plus one-half of the remainder is considered a work incentive and is deducted from the earned income. This deduction does not apply to income already excluded in this section.

(3) Income a client does not reasonably anticipate or which a client receives infrequently or irregularly is excluded when it is:

(a) Unearned and does not exceed twenty dollars per month; or

(b) Earned and does not exceed ten dollars per month.

(4) A client's work related expenses including child care are excluded when they specifically enable:

(a) A blind client to work; or

(b) A permanently or totally disabled client to continue to work.

(5) Any portion of self-employment income normally allowed as an income deduction by the Internal Revenue Service (IRS) is excluded.

(6) Any payment a client receives for the foster care of a child who lives in the same household, is excluded when the child:

(a) Was placed in the client's home by a public or non-profit child placement or child care agency; and

(b) Is not SSI eligible.

(7) One-third of any payment for child support a client receives from an absent parent for a minor child, who is not institutionalized, is excluded.

(8) A portion of an SSI-related person's income to meet the needs of an ineligible minor child living in the household is excluded when:

(a) The SSI-related parent is single; or

(b) If married, the spouse does not have income (see WAC 388-450-0150 if the spouse has income); and

(c) The excluded amount is:

(i) One-half of the one person federal SSI benefit rate, as described in WAC 388-478-0055; and

(ii) Minus any income of the child.

(9) Unless income is specifically contributed to the client, all earned income of an ineligible or nonapplying person, under twenty-one years of age, is excluded when this person is a student:

(a) Attending a school, college, or university; or

(b) Pursuing a vocational or technical training program designed to prepare the student for gainful employment.

(10) A client's veteran's benefits are excluded when they are designated for the veteran's:

(a) Dependent; or

(b) Aid and attendance/household allowance and unreimbursed medical expense allowance (UME). For an institutional client see WAC 388-513-1345.

(11) Any federal SSI income or state supplement payment (SSP), which is based on financial need is excluded.

(12) COLA increases in Title II Social Security Administration benefits are excluded for a noninstitutionalized client when:

(a) Received by the client after the client's termination from SSI/SSP or;

(b) Received by the client's spouse or other financially responsible person living in the household during the time period after the SSI/SSP termination.

(13) Income which causes a client to lose SSI eligibility due solely to the reduction in the SSP is excluded.

(14) Increases in a client's burial funds, established on or after November 1, 1982, are excluded if these increases are the result of:

(a) Interest earned on excluded burial funds;

(b) Appreciation in the value of an excluded burial arrangement which is left to accumulate and become part of separately identified burial funds.

(15) An essential expense incurred by a client to receive unearned income is excluded.

(16) A client's refund by any public agency of taxes paid on real property or on food is excluded.

(17) Tax rebates or special payments excluded under other statutes are excluded.

(18) The amount of a client's EITC payment is excluded.

(19) A fee a guardian or representative payee charges as reimbursement for providing services, when such services are a requirement for the client to receive payment of the income are excluded.

(20) Income a client's ineligible or nonapplying spouse receives from a governmental agency for services provided to an eligible client, such as chore services, are excluded.

(21) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services are excluded.

(22) Payments to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act are excluded. Any interest earned on this income is considered as unearned income, under WAC 388-450-0025.

(23) Payments to a client under section 500 through 506 of the Austrian General Social Insurance Act are excluded.

Any interest earned on this income is considered unearned income under WAC 388-450-0025.

(24) Payments to a client from the Dutch government, under the Netherlands' Act on Benefits for Victims of Persecution (WUV) are excluded. Any interest earned on this income is considered unearned income under WAC 388-450-0025.

(25) Other payments excluded under federal or state law, including but not limited to those described in WAC 388-450-0015 (1)(b) through (g).

(26) Payments from Susan Walker v. Bayer Corporation, et al., 96-c-5024 (N.D. Ill.) (May 8, 1997) settlement funds are excluded as income. Any interest earned on this income is considered unearned income under WAC 388-450-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1140 and 388-519-1910.]

WAC 388-450-0025 Unearned income. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Unearned income is income a person receives from a source other than employment or self-employment. Examples of unearned income include but are not limited to:

(a) Railroad retirement;

(b) Unemployment compensation; or

(c) Veteran administration benefits.

(2) For food assistance programs, unearned income includes the amount of cash benefits due the client prior to any reductions caused by the client's failure to perform an action required under a federal, state, or local means-tested public assistance program.

(3) Unearned income is budgeted in its entirety.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0030 Earned income definition. Unless specifically stated, this section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Earned income means:

(a) Income a person receives in the form of cash or in-kind, which is a gain or benefit to the person, when earned as a wage, salary, tips, gratuities, commissions, or profit from self-employment activities.

(b) Income over a period of time for which settlement is made at one time, such as sale of farm crops, livestock, or poultry.

(2) Earned income from self-employment is determined as specified under WAC 388-450-0080.

(3) For TANF/SFA, RCA, GA, and TANF/SFA-related medical assistance, earned income includes time-loss compensation as specified in WAC 388-450-0075.

(4) For food assistance programs only, income in-kind is excluded.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0035 Educational benefits. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) A student can exclude educational assistance in the form of grants, loans or work study, issued from Title IV of the Higher Education Amendments (Title IV - HEA) and Bureau of Indian Affairs (BIA) education assistance programs. Examples of Title IV - HEA and BIA educational assistance include but are not limited to:

- (a) College work study (federal and state);
- (b) Pell grants; and
- (c) BIA higher education grants.

(2) The following types of educational assistance, in the form of grants, loans, or work study, are not counted when determining a student's need:

(a) Assistance under the Carl D. Perkins Vocational and Applied Technology Education Act, P.L. 101-391 for attendance costs identified by the institution as specified in subsections (3) and (4) of this section; and

(b) Educational assistance made available under any program administered by the Department of Education (DOE) to an undergraduate student. Examples of programs administered by DOE include but are not limited to:

- (i) Christa McAuliffe Fellowship Program;
- (ii) Jacob K. Javits Fellowship Program; and
- (iii) Library Career Training Program.

(3) Educational assistance under subsection (2)(a) of this section for the following attendance costs is not counted when a student is attending school less than half-time:

- (a) Tuition;
- (b) Fees; and

(c) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study.

(4) Educational assistance under subsection (2)(a) of this section for a student attending school at least half-time for the following attendance costs in addition to the costs specified in subsection (3) of this section:

- (a) Books;
- (b) Supplies;
- (c) Transportation;
- (d) Dependent care; and
- (e) Miscellaneous personal expenses.

(5) For TANF/SFA, RCA, GA, and TANF/SFA-related medical assistance, the amount of a student's remaining educational assistance equal to the difference between the student's appropriate need standard and payment standard is excluded.

(6) Any remaining income is unearned income and budgeted using the appropriate budgeting method for the assistance unit.

(7) When a student participates in a work study program that is not excluded by subsections (1) and (2) of this section, the income received is treated as earned income:

- (a) Applying the applicable earned income disregards;
- (b) For TANF/SFA, RCA, GA, and TANF/SFA-related medical assistance, excluding the difference between the student's appropriate need standard and payment standard; and
- (c) Budgeting remaining income using the appropriate budgeting method for the assistance unit.

(8) When a student receives Veteran's Administration Educational Assistance:

- (a) All applicable attendance costs are subtracted; and
- (b) The remaining unearned income is budgeted using the appropriate budgeting method for the assistance unit.

(9) When a student participates in graduate school studies, educational assistance made available to the student is treated as unearned income.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0040 Native American benefits and payments. This section applies to TANF/SFA, RCA, GA medical and food assistance programs.

(1) The following types of income are not counted when a client's benefits are computed:

(a) Up to two thousand dollars per individual per calendar year received under the Alaska Native Claims Settlement Act, P.L. 92-203 and 100-241;

(b) Income received from Indian trust funds or lands held in trust by the Secretary of the Interior for an Indian tribe or individual tribal member. Income includes:

- (i) Interest; and
- (ii) Investment income accrued while such funds are held in trust.

(c) Income received from Indian judgement funds or funds held in trust by the Secretary of the Interior distributed per capita under P.L. 93-134 as amended by P.L. 97-458 and 98-64. Income includes:

- (i) Interest; and
- (ii) Investment income accrued while such funds are held in trust.

(d) Up to two thousand dollars per individual per calendar year received from leases or other uses of individually owned trust or restricted lands, P.L. 103-66;

(e) Payments from an annuity fund established by the Puyallup Tribe of Indians Settlement Act of 1989, P.L. 101-41, made to a Puyallup Tribe member upon reaching twenty-one years of age; and

(f) Payments from the trust fund established by the P.L. 101-41 made to a Puyallup Tribe member.

(2) Other Native American payments and benefits that are excluded by federal law are not counted when determining a client's benefits. Examples include but are not limited to:

(a) White Earth Reservation Land Settlement Act of 1985, P.L. 99-264, Section 16;

(b) Payments made from submarginal land held in trust for certain Indian tribes as designated by P.L. 94-114 and P.L. 94-540; and

(c) Payments under the Seneca Nation Settlement Act, P.L. 101-503.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1140.]

WAC 388-450-0045 Income from employment or training programs. This section applies to TANF/SFA, RCA, GA, and food assistance programs.

(1) Payments issued under the Job Training Partnership Act (JTPA) are treated as follows:

(a) Wages paid under JTPA are considered earned income.

(b) For TANF/SFA, RCA, and GA assistance, needs based payments issued under JTPA are considered as follows:

(i) Payments which cover special needs not covered in the need standard are excluded.

(ii) Payments which duplicate items contained in the need standard are excluded up to the difference between the student's appropriate need standard and payment standard.

(c) For food assistance, living allowances and incentive payments under JTPA are excluded as income.

(2) Payments issued under the National and Community Service Trust Act of 1993 (Americorps) are treated as follows:

(a) For cash assistance, living allowances or stipends paid under Americorps are considered earned income.

(b) For food assistance, living allowances or stipends paid under AmeriCorps are excluded income.

(3) Americorps/VISTA stipends and living allowances paid to VISTA volunteers under the Domestic Volunteer Act of 1973:

(a) For TANF/SFA, RCA, and GA assistance, are disregarded as income; and

(b) For food assistance, are disregarded as income, if the client received:

(i) Food assistance or cash assistance at the time they joined the Title I program; or

(ii) An income disregard for the Title I program at the time of conversion to the Food Stamp Act of 1977. Disregard of Title I program income will continue through temporary interruptions in food assistance participation.

(4) For TANF/SFA, RCA, and GA assistance, needs based payments issued under Americorps are treated like JTPA payments as provided in subsection (1)(b) of this section.

(5) For food assistance, training allowances from vocational and rehabilitative programs are earned income when:

(a) Recognized by federal, state, or local governments; and

(b) Not a reimbursement.

(6) For training allowances received by GA-U clients:

(a) The earned income incentive and work expense deduction specified under WAC 388-450-0175 is applied when applicable; and

(b) For clients enrolled in a remedial education or vocational training course, the actual cost of uniforms or special clothing required for the course is deducted from the training allowance.

(7) Support service payments received by or made on behalf of WorkFirst participants are not considered income.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0050 Income from the community jobs program. This section applies to the TANF/SFA program.

[Title 388 WAC—p. 576]

(1) The monthly wage received by a TANF/SFA client who participates in the community jobs (CJ) wage subsidy program is:

(a) Not counted as income for the first month of CJ participation; and

(b) Budgeted prospectively as defined in WAC 388-450-0215 beginning with the second month of CJ participation.

(2) The CJ participant's grant amount is computed by disregarding twenty percent of the expected income and treating the remainder as countable income.

(3) CJ participants are not subject to monthly reporting or income reporting requirements.

(4) When a change in income or resources causes the assistance unit's grant amount to be less than ten dollars or results in ineligibility, a CJ participant's cash grant:

(a) Will be suspended following rules in WAC 388-450-0245;

(b) Will continue to be suspended until participation is redetermined according to WAC 388-310-1300(8); and

(c) Can be in suspense for no more than nine months.

(5) Each month a CJ participant's cash grant is suspended will count toward the assistance unit's sixty month lifetime time limit for receipt of TANF/SFA benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0055 Assistance from other agencies and organizations. Unless specifically stated, this section applies to TANF/SFA, RCA, GA, medical and food assistance programs.

(1) Funds received from other agencies and organizations are excluded when determining the amount of assistance to be paid as long as no duplication exists between the assistance provided by the other agency and that provided by the department.

(2) To assure nonduplication, aid from other agencies will be considered in relation to:

(a) The different purposes for which such aid is granted;

(b) The provision of goods and services not included in the department's standards; and

(c) Conditions that preclude its use for current living costs.

(3) For TANF/SFA, RCA, GA, and TANF/SFA-related medical assistance, if the assistance from another agency is available to meet need, the assistance shall be disregarded up to the difference between the need standard and the payment standard.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0060 Lump sum payments. This section applies to TANF/SFA, RCA, GA, and TANF/SFA-related medical assistance. A one-time lump sum payment is treated as follows:

(1) Compensatory awards or related settlements are considered countable resources as provided in WAC 388-470-0080.

(2) For all other one-time lump sum payments, the amount equal to the difference between the client's countable

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resources and the resource limit is disregarded as income. The remaining amount is called the net lump sum payment and affects the client's eligibility and benefit amount as provided in WAC 388-450-0240.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0060, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0065 Gifts—Cash and noncash. A gift is an item furnished to a client without work or cost on his or her part.

(1) A cash gift is a gift that is furnished as money, cash, checks or any other readily negotiable form.

(a) For TANF/SFA, RCA, GA-S, GA-H, and TANF/SFA-related medical programs, cash gifts of up to thirty cumulative dollars per calendar quarter for each assistance unit member are disregarded as income.

(b) For GA-U and food assistance programs, cash gifts are treated as unearned income.

(2) For TANF/SFA, RCA, GA-S, GA-H, GA-U and TANF/SFA-related medical programs, a noncash gift is treated as a resource.

(a) If the gift is a countable resource, its value is added to the value of the client's existing countable resources and the client's eligibility is redetermined as specified in chapter 388-470 WAC.

(b) If the gift is an excluded or noncountable resource, it does not affect the client's eligibility or benefit level.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0065, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0070 A child's earned income. Unless otherwise specified, this section applies to TANF/SFA, RCA, GA-H and TANF/SFA-related medical programs. The earned income of a dependent child is:

(1) Excluded when determining if the total income of the assistance unit is more than one hundred eighty-five percent of the need standard in WAC 388-478-0015. This exclusion is limited to:

(a) Children who are full-time students; and

(b) No more than six month's in any calendar year.

(2) Not counted when determining the assistance unit's need and benefit level when the child is a:

(a) Full-time student; or

(b) Part-time student who is employed less than full-time.

(3) For food assistance programs, all earned income of a child is not counted when a child is:

(a) Seventeen years of age or younger; and

(b) Attending elementary or secondary school at least half time.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0070, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0075 Income from time-loss compensation. (1) Temporary disability insurance payments and temporary worker's compensation payments are treated as earned income for TANF/SFA, RCA, GA-S, GA-H, and TANF/SFA-related medical when such payments are:

(a) Employer funded and are analogous to sick pay; and

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(b) Made to an individual who remains employed during recuperation from a temporary illness or injury pending return to the job.

(2) Recurrent time loss benefits from the department of labor and industries are examples of benefits meeting this criteria.

(3) For TANF/SFA, RCA, GAS, GA-H and TANF/SFA-related medical programs, temporary disability insurance payments and temporary worker's compensation payments not considered to be earned income as described in subsection (1) and (2) of this section, are treated as unearned income as specified in WAC 388-450-0025.

(4) For the GA-U program, temporary disability insurance payments and temporary worker's compensation payments are treated as unearned income as specified in WAC 388-450-0025.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0075, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0080 Self-employment income—General rules. This section applies to TANF/SFA, RCA, GA, TANF/SFA-related medical and food assistance programs.

(1) Self-employment earned income is used to reduce a client's need for assistance. The income is treated as earned income as provided in WAC 388-450-0030.

(2) Self-employment earned income is defined as gross business income minus total allowable business expenses as defined in WAC 388-450-0085.

(3) In order to establish eligibility for assistance, a self-employed client must maintain and make available to the department a record clearly documenting all business expenses and income.

(4) Income from the following is treated as self-employment income:

(a) Adult family home;

(b) Farming;

(c) Roomers and boarders;

(d) Rental and lease of personal property or real estate owned by the client; and

(e) Self-produced or supplied items.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0080, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0085 Self-employment income—Allowable expenses. The following self-employment expenses are allowed as deductions from gross self-employment income for TANF/SFA, RCA, GA, medical and food assistance programs unless otherwise specified:

(1) Rent or lease of business equipment or property;

(2) Utilities;

(3) Postage;

(4) Telephone;

(5) Office supplies;

(6) Advertising;

(7) Business related insurance, taxes, licenses and permits;

(8) Legal, accounting, and other professional fees;

(9) For TANF/SFA, RCA, and GA assistance programs only, the cost of goods sold, including wages paid to employees producing salable goods, raw materials, stock, and

replacement or reasonable accumulation of inventory, provided inventory has been declared exempt on the basis of an agreed plan pursuant to chapter 388-470 WAC;

(10) Repairs to business equipment and property, excluding vehicles;

(11) Interest on business loans used to purchase income-producing property or equipment;

(12) Wages and salaries paid to employees not producing salable goods;

(13) Commissions paid to agents and independent contractors;

(14) Seed, fertilizer, and feed grain for a self-employed farmer;

(15) Other reasonable and necessary costs of doing business;

(16) The cost of the place of business. If any portion of the client's home is used as the place of business, it must be used exclusively for business to be an allowable business expense. The percentage of the home used for business can be an allowable business expense;

(17) The following transportation expenses are allowed as a deduction from gross self-employment income:

(a) Actual, documented costs for:

(i) Gas, oil, and fluids;

(ii) Replacing worn items such as tires;

(iii) Registration and licensing fees;

(iv) Auto loan interest; and

(v) Business related parking and tolls; or

(b) A cost per mile established by the department.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0085, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0090 Self-employment expenses that are not allowed as income deductions. (1) The following expenses cannot be deducted from self-employment income for TANF/SFA, RCA, GA, TANF/SFA-related medical or food assistance programs:

(a) Payments on the principle of the purchase price of income-producing:

(i) Real estate and capital assets;

(ii) Equipment;

(iii) Machinery; and

(iv) Other durable goods.

(b) Payments on the principal of loans to the business;

(c) Amounts claimed as depreciation;

(d) Any amount claimed as a net loss sustained in any prior period; and

(e) Entertainment expenses.

(2) The following expenses cannot be deducted from self-employment income for food assistance programs only:

(a) Federal, state, and local income taxes;

(b) Retirement funds; or

(c) Personal work-related expenses.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0090, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0095 Allocating income—General. This section applies to TANF/SFA, RCA, and GA assistance programs.

[Title 388 WAC—p. 578]

(1) Allocation is the process of determining how much of a financially responsible person's income is considered available to meet the needs of legal dependents within or outside of an assistance unit.

(2) In-bound allocation means income possessed by a financially responsible person outside the assistance unit which is considered available to meet the needs of legal dependents in the assistance unit.

(3) Out-bound allocation means income possessed by a financially responsible assistance unit member which is set aside to meet the needs of a legal dependent outside the assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0095, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0100 Allocating income—Definitions. The following definitions apply to the allocation rules for TANF/SFA, RCA, and GA programs:

(1) "Dependent" means a person who:

(a) Is or could be claimed for federal income tax purposes by the financially responsible person; or

(b) The financially responsible person is legally obligated to support.

(2) A "disqualified assistance unit member" means:

(a) An unmarried pregnant or parenting minor under age eighteen who has not completed a high school education or general education development (GED) certification and is not participating in those educational activities which would lead to the attainment of a high school diploma or GED;

(b) An unmarried pregnant or parenting minor under age eighteen who is not living in a department-approved living situation; and

(c) The financially responsible person who does not report to the department within five days of the date it becomes reasonably clear that the absence of a child will exceed ninety days.

(3) "Financially responsible person" means a parent, stepparent, adoptive parent, spouse or caretaker relative.

(4) "Ineligible assistance unit member" means an individual who:

(a) Is ineligible for cash assistance due to citizenship/alien status requirement in chapter 388-424 WAC;

(b) Has been disqualified from receiving assistance under WAC 388-446-0010 based on a conviction in federal or state court of having made a fraudulent statement or representation with respect to their place of residence in order to receive assistance from two or more states at the same time;

(c) Has been disqualified from receiving assistance under WAC 388-446-0005 based on a conviction for unlawfully receiving public assistance;

(d) Has been disqualified from receiving assistance under WAC 388-442-0010 for having been convicted after August 21, 1996, under federal or state law, of possession, use or distribution of a controlled substance;

(e) Is disqualified from receiving assistance under WAC 388-442-0010 for fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime;

(f) Is disqualified from receiving assistance under WAC 388-442-0010 for violating a condition of probation or parole

which was imposed under a federal or state law as determined by an administrative body or court of competent jurisdiction;

(g) Is the spouse of a woman who receives cash benefits from the GA-S program; and

(h) Is the adult parent of a minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0100, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0105 Allocating the income of a financially responsible person included in the assistance unit.

This section applies to TANF/SFA, GA-S, RCA, RMA and TANF-related medical programs. The income of a financially responsible person included in the assistance unit is countable to meet the needs of the assistance unit after the income is reduced by the following:

(1) Any applicable earned income incentive and work expense or deduction for the financially responsible person in the assistance unit, if that person is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0105, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0106 Allocating the income of a financially responsible person included in the assistance unit to household members excluded because of their alien status. This section applies to TANF/SFA, RCA, RMA and TANF/SFA-related medical programs.

When a financially responsible person, as defined in WAC 388-450-0100(3), is included in the assistance unit, that person's income is allocated to household members who are excluded from the assistance unit because of their alien status, as defined in WAC 388-450-0100 (4)(a), after allowing the following deductions:

(1) The fifty percent earned income incentive for TANF/SFA assistance units or the ninety dollar work expense deduction for RCA assistance units, if the income is earned;

(2) An amount equal to the difference between the payment standards:

(a) That would include the eligible assistance unit members and those individuals excluded from the assistance unit because of their alien status; and

(b) Only the eligible assistance unit members.

(3) The payment standard amount equal to the number of ineligible persons, as defined in WAC 388-450-0100 (4)(b) through (h);

(4) An amount not to exceed the need standard, as defined in WAC 388-478-0015, for court or administratively ordered current or back support paid for legal dependents; and

(5) The employment related child care expenses for which the household is liable.

[Statutory Authority: RCW 74.04.005 and 74.08.090. 98-24-037, § 388-450-0106, filed 11/24/98, effective 12/25/98.]

(1999 Ed.)

WAC 388-450-0110 Allocating the income of a GA-U client to legal dependents. This section applies to the GA-U program.

(1) The income of a GA-U client is reduced by the following:

(a) The GA-U earned income disregard and work expense disregard, as specified in WAC 388-450-0175; and

(b) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(2) When a GA-U client in a medical institution, alcohol or drug treatment center, congregate care facility or adult family home has income, the income is countable to meet the client's needs after the income is reduced by the following:

(a) The payment standard amount for the nonapplying spouse and legal dependents living in the home; and

(b) The standard of assistance the client is eligible for while in an alternative care facility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-519-1910.]

WAC 388-450-0115 Allocating the income of a financially responsible person excluded from the assistance unit. This section applies to TANF/SFA, RCA and GA-S programs.

The income of a financially responsible person excluded from the assistance unit is available to meet the needs of the assistance unit after the income is reduced by the following:

(1) A ninety dollar work expense deduction from the financially responsible person(s) excluded from the assistance unit who is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0115, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0116 Allocating the income of a financially responsible person excluded from the assistance unit because of their alien status. This section applies to TANF/SFA and RCA programs.

When a financially responsible person, as defined in WAC 388-450-0100(3), is excluded from the assistance unit because of their alien status, as defined in WAC 388-450-0100 (4)(a), that person's income, after allowing the following deductions, is countable income available to the assistance unit:

(1) The fifty percent earned income incentive for TANF/SFA assistance units or the ninety dollar work expense deduction for RCA assistance units, if the income is earned;

(2) An amount equal to the difference between the payment standards:

(a) That would include the eligible assistance unit members and those individuals excluded from the assistance unit because of their alien status; and

(b) Only the eligible assistance unit members.

[Title 388 WAC—p. 579]

(3) The payment standard amount equal to the number of ineligible persons, as defined in WAC 388-450-0100 (4)(b) through (h);

(4) An amount not to exceed the need standard, as defined in WAC 388-478-0015, for court or administratively ordered current or back support paid for legal dependents; and

(5) The employment related child care expenses for which the household is liable.

[Statutory Authority: RCW 74.04.005 and 74.08.090. 98-24-037, § 388-450-0116, filed 11/24/98, effective 12/25/98.]

WAC 388-450-0120 Allocating the income of financially responsible parents to a pregnant or parenting minor. This section applies to TANF/SFA, RCA and GA-S programs.

The income of nonapplying financially responsible parent(s) of a pregnant or parenting minor is countable to meet the needs of the minor and the child(ren) after the income is reduced by the following:

(1) A ninety dollar work expense from the financially responsible parent's gross income from employment;

(2) An amount not to exceed the department's standard of need for:

(a) The financially responsible parent and dependent living in the home who are not applying for or receiving cash benefits and not a disqualified individual; and

(b) Court or administratively ordered current or back support for legal dependents.

(3) Spousal maintenance payments made to meet the needs of individuals not living in the home.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0120, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0125 Allocating the income of the father of the unborn child to a pregnant woman. This section applies to TANF/SFA, RCA and GA-S programs.

(1) Income of the father of the unborn child is allocated to a pregnant woman under the following conditions:

(a) The need standard, as provided in WAC 388-478-0015 that reflects the number of people in the assistance unit as though the child were born when applying the one hundred eighty-five percent of need test as specified in WAC 388-450-0015. The father is included when he is residing in the client's home.

(b) The payment standard, as provided in WAC 388-478-0025 that reflects the number of people in the assistance unit as though the child were born. The father is included when he is residing in the client's home.

(2) When the parents are married and the father resides in the client's home, his income is allocated according to rules in WAC 388-450-0115.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0125, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0130 Allocating the income of a non-applying spouse to a caretaker relative. This section applies to TANF/SFA and RCA programs.

(1) The community income of the nonapplying spouse and applying spouse is combined. See WAC 388-450-0005 to determine what income is available as community income.

(2) Subtract a one person payment standard as specified in WAC 388-478-0020.

(3) The remainder is allocated to the caretaker relative.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0130, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0135 Allocating income of an ineligible spouse to a GA-U client. (1) This section applies to the GA-U program.

(2) When a GA-U client is married and lives with the nonapplying spouse, the following income is available to the client:

(a) The remainder of the client's wages, retirement benefits or separate property after reducing the income by:

(i) The GA-U work incentive and work expense deduction, as specified in WAC 388-450-0175; and

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(b) The remainder of the nonapplying spouse's wages, retirement benefits and separate property after reducing the income by:

(i) The GA-U work expense deduction;

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents; and

(iii) The payment standard amount as specified under WAC 388-478-0030 which includes ineligible assistance unit members.

(c) One-half of all other community income, as provided in WAC 388-450-0005.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0135, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0140 Income of ineligible assistance unit members—Food assistance. (1) When a food assistance unit contains a person who is disqualified for intentional program violation or failure to meet work requirements as provided in chapter 388-444 WAC, all income of the disqualified person is included as part of the entire assistance unit's income:

(a) The standard deduction and allowable deductions for earned income, medical costs, dependent care, and excess shelter costs are applied; and

(b) The assistance unit's coupon allotment is not increased as a result of the exclusion of the disqualified person.

(2) When an assistance unit contains a person who is ineligible due to alien status or failure to sign the application attesting to citizenship or alien status or who has been disqualified for refusal to obtain or provide a Social Security number:

(a) A share of the income of the ineligible person is counted as income to the eligible assistance unit members after prorating the income among all members, including the ineligible member, and excluding the ineligible person's share;

(b) The twenty percent earned income deduction is applied to the ineligible person's earned income attributed to the assistance unit; and

(c) The portion of the assistance unit's allowable shelter and dependent care expense which is paid by or billed to the ineligible person is divided evenly among all members of the assistance unit, provided the ineligible members have income.

(3) The ineligible or disqualified assistance unit member is not counted when determining the assistance unit's size for purposes of:

(a) Comparing the assistance unit's total monthly income to the income eligibility standards; and

(b) Computing benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0140, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0145 Income of a person who is not a member of a food assistance unit. (1) A cash payment made to a food assistance unit from a person who is not a member of the assistance unit is counted as unearned income.

(2) The following types of income are not available to the assistance unit:

(a) The nonmember's income; and

(b) Payments made by a nonmember to a third party for the benefit of the assistance unit.

(3) When the nonmember's earnings are not clearly separate from the earnings of food assistance unit members, the earnings are:

(a) Divided equally among the working persons, including the nonmember; and

(b) The portion of the nonmember is not counted.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0145, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0150 SSI-related medical income allocation. (1) When a client is applying for SSI-related categorically needy (CN) or medically needy (MN) medical assistance, a portion of the income of a spouse or parent is allocated to the needs of the applicant. This occurs when the spouse or parent is:

(a) Financially responsible for the SSI-related person as described in chapter 388-408 WAC; and

(b) Lives in the same household; and

(c) Is not receiving SSI; and

(d) Is either not related to SSI or is not applying for medical assistance.

(2) If the conditions in subsection (1) of this section are met, the income exclusions listed below are applied and the remainder of the parent's income is allocated to their SSI-related minor child applying for either (CN) or (MN) medical assistance:

(a) Income exclusions as described in WAC 388-450-0020; and

(b) One-half of the federal benefit rate (FBR), as described in WAC 388-478-0055, for each SSI ineligible child in the household, minus any income of that child; and

(c) A one person FBR for a single parent, or two person FBR for two parents.

(1999 Ed.)

(3) The income of the financially responsible spouse of an SSI-related client applying for CN or MN medical assistance is allocated to the applicant's needs.

(a) The income exclusions in WAC 388-450-0020 (3) through (26) are allowed to reduce the nonapplying spouse's income; and

(b) One-half of the FBR for any non-SSI eligible child in the household, minus any income of that child, is allowed as a deduction; and

(c) Allocate the applying spouse:

(i) Zero income when the financially responsible spouse's income equals or is less than one-half of the FBR after allowing the income exclusions in WAC 388-450-0020 (1) and (2); or

(ii) All of the financially responsible spouse's income when the income exceeds one-half of the FBR after allowing the income exclusions in WAC 388-450-0020 (1) and (2).

(4) If the income of the financially responsible spouse described in subsection (3) of this section is less than the MNIL, a portion of the SSI-related applicant's income is added to the financially responsible spouse's income to raise it to the MNIL.

(5) If an alien client is ineligible for SSI cash assistance because of income or resources of a sponsor allocated or deemed available to the client, the SSI-related client is still considered eligible for CN or MN medical assistance. Only the income or resources actually contributed to the alien client are considered available to that client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0150, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0630 and 388-519-1910.]

WAC 388-450-0155 Deeming income—Alien sponsorship. This section applies to TANF/SFA and GA programs.

(1) Deeming is the process of determining the amount of an alien's sponsor's income available to the alien.

(2) Any alien whose sponsor is a public or private organization is ineligible for assistance for three years from the date of entry for permanent residence into the United States, unless the agency or organization is:

(a) No longer in existence; or

(b) Has become unable to meet the alien's needs.

(3) A sponsor is any individual or public or private organization who executes an affidavit or similar agreement on behalf of an alien (who is not the dependent child of the sponsor or the sponsor's spouse) as a condition of the alien's entry into the United States.

(a) The affidavit or agreement is irrevocable, and

(b) Extends for a minimum of three years after the alien's entry for permanent residence into the United States.

(4) For a period of three years following entry for permanent residence into the United States, an individually sponsored alien is responsible for:

(a) Providing the department with any information and documentation necessary to determine the income of the sponsor that can be deemed available to the alien; and

(b) Obtaining any cooperation necessary from the sponsor.

(5) For all subsections in this section, the income of an individual sponsor (and the sponsor's spouse if living with the sponsor) is deemed to be the unearned income of an alien for three years following the alien's entry for permanent residence into the United States.

(6) Monthly income deemed available to the alien from the individual sponsor or the sponsor's spouse not receiving TANF/SFA or SSI is:

(a) The sponsor's total monthly unearned income, added to the sponsor's total monthly earned income reduced by twenty percent (not to exceed one hundred seventy-five dollars) of the total of any amounts received by the sponsor in the month as wages or salary or as net earnings from self-employment, plus the full amount of any costs incurred in producing self-employment income in the month.

(b) The amount described in (a) of this subsection reduced by:

(i) The basic requirements standard for a family of the same size and composition as the sponsor and those other persons living in the same household as the sponsor claimed by the sponsor as dependents to determine the sponsor's federal personal income tax liability but who are not TANF/SFA recipients;

(ii) Any amounts actually paid by the sponsor to persons not living in the household claimed by the sponsor as dependents to determine the sponsor's federal personal income tax liability; and

(iii) Actual payments of spousal maintenance or child support with respect to persons not living in the sponsor's household.

(7) In any case where a person is the sponsor of two or more aliens, the sponsor's income is divided equally among the aliens to the extent that the income would be deemed the income of any one of the aliens under provisions of this section.

(8) The income deemed to a sponsored alien in determining the need of other unsponsored members of the alien's family is not considered except to the extent that the income is actually available.

(9) For the GA-U program, the alien's sponsor's income is deemed as available to the alien as provided for the TANF/SFA program:

(a) At application, for applications filed on or after July 8, 1994. For the purposes of this rule, re-application filed following a break in assistance of thirty days or more is considered an application; and

(b) For all other GA-U clients, the income of an alien's sponsor is not deemed as available to the client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0155, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0160 Sponsored alien—Food assistance. For food assistance, this section applies to aliens for whom a sponsor has signed an affidavit of support or similar statement on or after February 1, 1983:

(1) Portions of the income of a sponsor and sponsor's spouse are counted as unearned income and applied to the food assistance benefits of a sponsored alien if living with the sponsor. The income of an alien's sponsor is available for

three years following the alien's admission for permanent residence to the U.S.

(2) The income of the alien's sponsor and sponsor's spouse must be verified by the client if the client is living with the sponsor at application or recertification for food assistance.

(3) The available income is computed as follows:

(a) Total monthly earned and unearned income of the sponsor and sponsor's spouse:

(i) Minus twenty percent of the gross earned income; and

(ii) Minus the amount of the gross income eligibility standard for a household size equal to the sponsor, the sponsor's spouse, and all dependents.

(b) Plus any actual money paid to the alien by the sponsor or sponsor's spouse in excess of the amount computed in subsection (3)(a) of this section is treated as unearned income.

(4) The net income in subsection (3) of this section is available to a sponsored alien who:

(a) Applies for and receives food assistance; or

(b) Is recertified for food assistance.

(5) If the sponsored alien can show the sponsor is also sponsoring other aliens, the available income is divided by the number of sponsored aliens applying for, or receiving food assistance.

(6) If an alien changes sponsors during the certification period, available income is reviewed based on the required information about the new sponsor as soon as possible after the information is supplied and verified by the client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0160, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0165 Gross earned income limit for TANF/SFA. When applying the gross earned income limit as required under WAC 388-478-0035:

(1) "Family" means:

(a) All adults and children who would otherwise be included in the assistance unit under WAC 388-408-0015, but who do not meet TANF/SFA eligibility requirements;

(b) The unborn child of a woman in her third trimester of pregnancy; and

(c) The husband of a woman in her third trimester of pregnancy, when residing together.

(2) "Gross earned income" does not include excluded income, as provided in WAC 388-450-0015.

(3) The following amounts are disregarded when determining a family's gross earned income:

(a) Court or administratively ordered current or back support paid to meet the needs of legal dependents, up to:

(i) The amount actually paid; or

(ii) A one-person need standard for each legal dependent.

(b) Authorized ongoing additional requirement payment as defined in WAC 388-255-1050 through 388-255-1250.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0165, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0170 TANF/SFA earned income incentive and deduction. (1) This section applies to:

(a) TANF/SFA, GA-S, GA-H; and

(b) TANF/SFA-related medical programs except as specified under WAC 388-450-0210.

(2) When determining countable income, fifty percent of a client's monthly gross earned income is disregarded as an incentive to employment.

(3) The actual cost of care of each dependent child or incapacitated adult living in the same home and receiving TANF/SFA is deducted when determining countable income under the following conditions:

(a) An applicant is eligible for a dependent care deduction for expenses incurred prior to the open effective date in the month of grant opening on a prorated basis;

(b) A recipient is eligible for a dependent care deduction if:

(i) The assistance unit received AFDC on October 13, 1988;

(ii) The dependent care deduction was applied when determining the benefit level for that month;

(iii) The assistance unit has remained continuously eligible for AFDC or TANF/SFA since that time; and

(iv) The assistance unit has chosen to use the deduction rather than state-paid dependent care.

(4) The dependent care deduction specified in subsection (3) of this section is not allowed unless:

(a) The care provided by a parent or stepparent;

(b) The care provider verifies the cost incurred;

(c) The cost is incurred for the month of employment being reported; and

(d) The amount deducted for each dependent child or incapacitated adult, depending on the number of hours worked per month does not exceed the following:

Dependent Care Maximum Deductions

Hours Worked Per Month	Dependent Two Years of Age or Older	Dependent Under Two Years of Age
0 - 40	\$ 43.75	\$ 50.00
41 - 80	\$ 87.50	\$100.00
81 - 120	\$131.25	\$150.00
121 or More	\$175.00	\$200.00

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0170, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0175 GA-U earned income incentive and deduction. This section applies to the GA-U cash assistance program.

(1) When a client's countable income is determined, eighty-five dollars plus one half of the remainder of a client's monthly gross earned income is disregarded as an incentive to employment.

(2) In addition to the work incentive provided in subsection (1) of this section, work expenses are disregarded in an amount equal to twenty percent of the gross earned income; or

(3) At the option of the client, actual verified work expenses, including:

(a) Mandatory deductions required by law or as a condition of employment, such as FICA, income tax, and mandatory retirement contributions;

(b) Union dues when union membership is required for employment;

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(c) Clothing costs when the clothing is necessary for employment;

(d) Tools necessary for employment;

(e) Other expenses reasonably associated with employment, such as legally binding contracts with employment agencies; and

(f) Transportation expenses as follows:

(i) If public transportation (other than for-hire vehicles such as taxis) is available and practical, the actual monthly cost, based on a commuter's pass, ticket book, or tokens at reduced quantity rates, even if the client does not use public transportation; or

(ii) If public transportation is not available or practical, the actual amount if the client pays another person to drive; or

(iii) If public transportation is not available or practical and the client uses his or her own vehicle, the costs, based on the percentage of work-related miles driven, for service and repairs, replacement of worn parts, registration and license fees, the interest on car payments, and either eight cents per mile or the actual cost for gas, oil, fluids, and depreciation.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0175, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0180 Effect of countable income on eligibility and benefit level for cash assistance. (1) For TANF/SFA, RCA, GA assistance, countable income is income which:

(a) Cannot be excluded under the rules of this chapter;

(b) Cannot be allowed as a deduction, earned income incentive, out-bound allocation, or otherwise disregarded under the rules of this chapter; and

(c) Includes all in-bound income allocated or deemed from financially responsible persons who are not members of the assistance unit.

(2) A client's recurring monthly countable income is used to determine the client's eligibility and benefit amount following budgeting methods described in WAC 388-450-0215 or 388-450-0220.

(3) When an assistance unit's countable income is equal to or exceeds the appropriate payment standard plus authorized additional requirements, the client is not eligible for benefits.

(4) When an assistance unit's countable income is less than the appropriate payment standard plus authorized additional requirements, the client's benefit level is equal to the difference.

(5) Nonrecurring lump sums affect eligibility and benefit level as specified in WAC 388-450-0060 and 388-450-0240.

(6) When a change in income causes ineligibility for more than one month, the effective date of ineligibility is determined as follows:

(a) When recurrent income received in the budget month causes ineligibility, the assistance unit is ineligible on the first day of the payment month if the following circumstances are met:

(i) The assistance unit is subject to retrospective income budgeting as specified in WAC 388-450-0220; and

(ii) The income is reported timely as required under chapters 388-418 and 388-456 WAC.

(b) For all other changes in recurring income which cause ineligibility, the assistance unit is ineligible on the first day of the month the income is received.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0180, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0185 General information regarding income deductions for food assistance programs. The following income deductions are used to compute food assistance program benefits:

(1) A standard deduction of one hundred thirty-four dollars per household per month;

(2) An earned income deduction of twenty percent gross earned income;

(3) A portion of the actual monthly amount of dependent care deduction:

(a) Needed for an assistance unit member to seek, accept or continue employment; or

(b) Needed for an assistance unit member to attend training or education preparatory to employment; and

(c) Not to exceed two hundred dollars for each dependent one year of age or younger; or

(d) Not to exceed one hundred seventy-five dollars for each other dependent.

(4) A deduction for nonreimbursable monthly medical expenses over thirty-five dollars incurred or anticipated to be incurred by an elderly or disabled household member as specified under WAC 388-450-0200.

(5) A deduction for legally obligated child support paid for a person who is not a member of the household.

(6) Shelter costs as provided in WAC 388-450-0190.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0185, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0190 Shelter cost income deductions for food assistance. (1) Shelter costs include:

(a) Rent, lease payments and mortgage payments; and

(b) Utility costs.

(2) Shelter costs are deducted from gross income if the costs are in excess of fifty percent of the assistance unit's income after deducting the standard, earned income, medical, child support, and dependent care deductions:

(a) For an assistance unit containing an elderly or disabled member the entire amount of excess shelter costs is deducted;

(b) For all other assistance units the excess shelter cost deduction cannot exceed two hundred and fifty dollars.

(3) Shelter costs may include:

(a) Costs for a home not occupied because of employment, training away from the home, illness, or abandonment caused by casualty loss or natural disaster if the:

(i) Assistance unit intends to return to the home;

(ii) Current occupants, if any, are not claiming shelter costs for food assistance purposes; and

(iii) The home is not being leased or rented during the assistance unit's absence.

(b) Charges for the repair of the home which was substantially damaged or destroyed due to a natural disaster.

(c) The standard utility allowance or actual utility costs as provided in WAC 388-450-0195.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0190, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0195 Utility allowances for food assistance programs. (1) You can use the amounts in the chart below or use actual utility costs to calculate total shelter costs. Total shelter costs are used in calculating your food assistance benefits.

If you have to pay:

Separate heating or cooling costs

Separate utility costs, but no heating or cooling costs

Separate costs for phone service only

Then, you can use the:

Standard utility allowance (SUA) of \$211

Limited utility allowance (LUA) of \$158

Telephone utility allowance (TUA) of \$29

(2) Use actual utility costs if greater than the SUA or LUA or if you are not eligible for the SUA or LUA.

[Statutory Authority: RCW 74.04.510 and 7 CFR 273.9 (d)(6). 99-01-069, § 388-450-0195, filed 12/14/98, effective 1/14/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0195, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0200 Medical cost income deductions for food assistance. (1) Excess medical and/or shelter deductions paid by the client are allowed when a client:

(a) Is elderly or disabled;

(b) Received food assistance as a noncash assistance unit until becoming categorically eligible due to the receipt of SSI; or

(c) Became categorically eligible due to the receipt of SSI after noncash assistance food stamps were denied as provided under chapter 388-414 WAC.

(2) One-time medical expenses are averaged over the certification period, at the client's option.

(3) A medical expense deduction is not allowed when the expense is:

(a) A reimbursement;

(b) A vendor payment, except for Low Income Home Energy Assistance Act (LIHEAA) payments;

(c) Claimed after the initial billing, even though:

(i) Not reported when first due;

(ii) Included in the most recent billing; and

(iii) Actually paid.

(d) Allowed as a deduction once but not paid, and subsequently included in a repayment agreement;

(e) Included in a timely but defaulted repayment agreement and then included in a subsequent repayment agreement;

(f) Claimed by a client after presumptive SSI is denied;

(g) Considered overdue to the provider; or

(h) Already paid by a prospectively budgeted assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0200, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0205 Budgeting income deductions for food assistance. (1) Allowable medical expenses are budgeted prospectively for the entire certification period.

(2) Income exclusions and deductions other than allowable medical expenses are budgeted:

(a) Prospectively when all assistance unit income is budgeted prospectively;

(b) Retrospectively when all assistance unit income is budgeted retrospectively; or

(c) Retrospectively when part of the assistance unit's income is budgeted prospectively and part is budgeted retrospectively.

(3) Additional public assistance payments are budgeted either prospectively or retrospectively, using only the amount authorized for the month the income is received.

(4) Expenses are averaged either prospectively or retrospectively over the period the expense is intended to cover if the assistance unit:

(a) Has expenses that fluctuate or are billed less often than monthly; and

(b) Chooses to have the expense averaged.

(5) For food assistance, countable income is income which:

(a) Cannot be excluded under the rules of this chapter;

(b) Cannot be allowed as a deduction, earned income incentive, out-bound allocation, or otherwise disregarded under the rules of this chapter; and

(c) Includes all in-bound income allocated or deemed from financially responsible persons who are not members of the assistance unit.

(6) An assistance unit's monthly countable income is used to:

(a) Determine eligibility, if required, based on the monthly net earned income standard specified in WAC 388-478-0060; and

(b) Calculate the assistance unit's monthly benefit level.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0205, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0210 Countable income for medical programs.

(1) For purposes of medical program eligibility, a client's countable income is income which remains when:

(a) The income cannot be specifically excluded; and

(b) All appropriate deductions and disregards allowed by a specific program, have been applied.

(2) A client's countable income cannot exceed the income standard for the specific medical programs described in WAC 388-478-0065 through 388-478-0085 unless:

(a) The program allows the spenddown of excess income; or

(b) The program makes an allowance for those limits to be exceeded.

(3) Unless modified by subsection (4) of this section, the TANF/SFA income methodology, as described in this chapter, is used to determine a client's countable income for the following programs:

(a) TANF/SFA-related categorically needy (CN) or medically needy (MN);

(b) TANF/SFA-related CN extended medical as described in chapter 388-523 WAC;

(c) Pregnant women's program, CN or MN;

(d) Children's medical program, CN or MN;

(e) Children's health program;

(f) SFA-related medical; and

(g) Medically Indigent (MI) program.

(4) Exceptions to the TANF/SFA cash assistance methodology apply as follows:

(a) The financial responsibility of relatives is more limited when a client is applying for medical as specified in chapter 388-408 WAC;

(b) Income is always prospectively budgeted for medical;

(c) Actual work related child care expenses, which are the client's responsibility, are income deductions (the limits on this deduction in WAC 388-450-0170 (3) and (4) do not apply);

(d) Court or administratively ordered current or back support paid to meet the needs of legal dependents, are income deductions;

(e) Income actually contributed to an alien client from the alien's sponsor;

(f) TANF/SFA gross earned income limits as described in WAC 388-450-0165 do not apply;

(g) The fifty percent work incentive is not used to calculate countable income for programs with income levels based upon the Federal Poverty Level (FPL). These programs are listed in subsection (3)(b), (c), (d) and (e) of this section. The only work related income deductions for these programs are:

(i) Ninety dollars; and

(ii) Actual work related child care expenses, as described in subsection (4)(c) of this section.

(h) A nonrecurring lump sum payment is considered as income in the month the client receives payment, and a resource if the client retains the payment after the month of receipt.

(5) SSI income methodology is used to determine a client's countable income for:

(a) SSI-related CN or MN; and

(b) Medicare cost sharing programs.

(6) Exceptions to the SSI income methodology apply as follows:

(a) Lump sum payments are excluded as income;

(b) The interest portion of a payment a client receives from a sales contract which is a nonexcluded resource is treated as unearned income; and

(c) The principle and interest portions of a payment a client receives from a sales contract, which meets the definition in WAC 388-470-0040(3), are treated as unearned income.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0210, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580, 388-505-0590 and 388-519-1910.]

WAC 388-450-0215 Prospective budgeting. Unless specifically stated, this section applies to TANF/SFA, RCA, GA, medical and food assistance programs.

(1) Prospective budgeting means an assistance unit's benefit amount for the month is computed using the best estimate of income and circumstance for that month.

(2) Best estimate means a reasonable expectation and knowledge of current, past and future circumstances. For TANF/SFA, RCA and GA assistance:

(a) An overpayment is established if the income is underestimated; and

(b) A corrective payment is issued if the income is overestimated.

(3) For medical assistance programs, the assistance unit's income is always prospectively budgeted.

(4) For TANF/SFA, RCA, GA, and food assistance programs, an assistance unit's income and circumstances are prospectively budgeted:

(a) For the first two months of benefit eligibility;

(b) When the benefits have been closed for less than one month and were closed in the first prospectively budgeted month; or

(c) When the assistance unit's benefits are suspended, as defined in WAC 388-450-0245 and the assistance unit experiences a significant change in their income, such as loss of employment, in the budget or process month.

(5) For each month of benefit eligibility certain assistance units will have their income prospectively budgeted. This applies to assistance units in which:

(a) All adult members are elderly or disabled and do not have earned income or recent work history, as defined in WAC 388-404-0015, 388-400-0040 and 388-456-0010;

(b) The members are migrant workers. A migrant worker is a person who works in seasonal agricultural employment that requires the person to be away from their permanent place of residence overnight;

(c) All members are homeless as defined in WAC 388-408-0050; or

(d) For food assistance programs the only income is from seasonal farm work:

(i) A seasonal farm worker is a person working in seasonal agricultural employment but not required to be away from their permanent place of residence overnight; and

(ii) A seasonal farm worker assistance unit means an assistance unit which receives its only income from seasonal farm work or unemployment compensation.

(6) Public assistance income is budgeted prospectively.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0215, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0590.]

WAC 388-450-0220 Retrospective budgeting. This section applies to all TANF/SFA, RCA, GA, and food assistance programs.

(1) Retrospective budgeting means the assistance unit's benefit amount for the payment month is computed using the actual income and circumstances of the budget month.

(a) The budget month is the month in which the income is received by the client.

(b) The process month is the month following the budget month. It is the month during which the department computes the client's benefit amount when income from the budget month is reported timely.

(c) The payment month is the month following the process month.

(2) After the first two months of benefit eligibility, an assistance unit's income and circumstances are retrospectively budgeted, except when the assistance unit:

(a) Is listed in WAC 388-450-0215(5); and

(b) Has discontinued income, as defined in WAC 388-450-0235.

(3) An assistance unit's initial month's benefits are retrospectively budgeted when:

(a) The assistance unit's benefits are reopened after being closed in error;

(b) The assistance unit's benefits are reopened after being closed less than one month and closed after the first initial month of eligibility;

(c) A person with income is added to the assistance unit and their income had been allocated to the assistance unit; or

(d) The assistance unit's benefits were suspended, as defined in WAC 388-450-0245, and:

(i) The first month of eligibility follows the month of suspension; and

(ii) The assistance unit has not experienced a significant change, as provided in WAC 388-450-0245.

(4) Income from a discontinued source that was prospectively budgeted during the first two months of eligibility, may be excluded for retrospective budgeting as specified in WAC 388-450-0235.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0220, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0225 Budgeting income for cash assistance applicants. The grant amount for the month of application is computed as follows:

(1) All countable income to be budgeted during the first calendar month of eligibility is subtracted from the payment level plus authorized additional requirements; and

(2) The grant is prorated for the remaining number of days in the month beginning with the effective date of eligibility. This prorated figure is the benefit level for the first month of eligibility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0225, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0230 Treatment of income in the month of application for destitute food assistance households. (1) When a migrant or seasonal farm worker is determined destitute under WAC 388-406-0020, eligibility and benefit amount for the month of application is determined by:

(a) Counting the household's income that is received from the first of the month through the date of application; and

(b) Excluding income from a new source that the household expects to receive during the ten days after the date of application.

(2) A household member changing jobs but continuing to work for the same employer is considered to be receiving income from the same source.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0230, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0235 Discontinued income. (1) For TANF/SFA, RCA, GA, and food assistance programs, discontinued income means income which was available but is no longer received.

(2) When income of an assistance unit was used to determine the benefit amount in the first two months of eligibility

has stopped, the income is not used to determine benefits for the following months.

(3) For food assistance programs, clients who report during the budget month that income stopped that month will not have the income counted for the corresponding payment month.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0235, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0240 Effect of net lump sum payments for cash assistance. For TANF/SFA, RCA, and GA assistance, a net lump sum payment, as determined under WAC 388-450-0060, effects the client's eligibility and benefit amount as follows:

(1) When the net lump sum payment is less than the client's payment standard plus additional requirements for one month, the payment is retrospectively budgeted as specified in WAC 388-450-0220.

(2) When the net lump sum payment is more than one month's payment standard plus additional requirements but less than two months, the payment is budgeted following the retrospective monthly budgeting cycle specified in WAC 388-450-0220. The lump sum payment effects the client's eligibility and benefit level as follows:

(a) The grant for the payment month corresponding to the month the payment was received is suspended; and

(b) The remainder of the lump sum payment is treated as countable income when determining the benefit level for the month following the grant suspension month.

(3) When the net lump sum payment is at least twice a client's payment standard plus additional requirements, the client is not eligible for cash benefits for the month the lump sum payment was received and the following month.

(4) A client's period of ineligibility as established in subsection (3) of this section can be reduced when:

(a) The client's payment standard increases;

(b) For reasons beyond a client's control, any or all of the one-time lump sum payment becomes unavailable; or

(c) The client or other members of the assistance unit become responsible for or pay medical expenses.

(5) When an ineligible or disqualified client receives a one-time lump sum payment:

(a) The payment is first allocated to meet the needs of the ineligible or disqualified client, as specified in WAC 388-450-0105; and

(b) The remaining income is treated as a lump sum payment according to the rules of this section.

(6) To avoid a period of ineligibility as specified in subsection (3) of this section, a client may request termination of their cash benefits the month before the receipt of a lump sum payment.

(7) For TANF/SFA-related medical programs, nonrecurring lump sum payments are:

(a) Counted as income in the month received; and

(b) Any money that remains on the first of the next month is counted as a resource.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0240, filed 7/31/98, effective 9/1/98.]

(1999 Ed.)

WAC 388-450-0245 Suspending benefits. This section applies to TANF/SFA, RCA, GA and food assistance programs.

(1) An assistance unit's benefits are suspended when the assistance unit's countable net income makes the assistance unit ineligible for one payment month.

(2) An assistance unit's benefits will be suspended rather than terminated when:

(a) There is reason to believe the assistance unit would be ineligible for benefits for only one payment month; and

(b) The cause was due to income or other circumstances in the corresponding budget month.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0245, filed 7/31/98, effective 9/1/98.]

WAC 388-450-0250 Income of a new assistance unit member. This section applies to all TANF/SFA, RCA, GA, medical and food assistance programs.

(1) A client's income is treated as specified in chapter 388-418 WAC when the client enters an assistance unit.

(2) When a recipient establishes a separate assistance unit:

(a) That client is removed from the prior assistance unit; and

(b) The method of income budgeting that was in effect in the prior assistance unit is used for the new assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-450-0250, filed 7/31/98, effective 9/1/98.]

Chapter 388-452 WAC INTERVIEW REQUIREMENTS

WAC

388-452-0005 Interview requirements.

388-452-0010 What does the family violence amendment mean for TANF/SFA recipients?

WAC 388-452-0005 Interview requirements. (1) Persons applying for assistance programs have a single in-office interview unless an alternate type of interview is requested and approved. The interview is conducted in:

(a) A community services office; or

(b) A Social Security Administration district office for SSI applicant or recipient assistance units applying for food assistance programs.

(2) The person who attends the eligibility interview is:

(a) For food assistance, a responsible member of the assistance unit or an authorized representative as defined in WAC 388-462-0005; or

(b) For cash assistance and medical, an applicant or someone representing the applicant when the applicant is unable to come into the office.

(3) TANF and SFA assistance units are required to have an in-office interview at least once every twelve months for redetermination of eligibility.

(4) A client may bring anyone to the interview.

(5) Persons applying for medical only are not required to have an in-office interview when the person:

(a) Is pregnant and the application is for a pregnancy-related program; or

(b) Is applying only for a child under nineteen years of age and the application is for a medical program for children.

(6) Applicants may have an alternate type of interview rather than an in-office interview. An alternate type of interview is completed:

- (a) By telephone;
- (b) By a scheduled home visit; or
- (c) For medical only programs, through the mail.

(7) Applicants may have an alternate type of interview when they request an alternate type and:

- (a) They are unable to appoint an authorized representative;
- (b) They do not have a responsible assistance unit member able to come into the office because of hardships; or
- (c) For medical programs, there is adequate information to determine eligibility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-452-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0420.]

WAC 388-452-0010 What does the family violence amendment mean for TANF/SFA recipients? The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), also known as the Welfare Reform Act, gave every state the option to have a program to address issues of family violence for temporary assistance for needy families (TANF) and state family assistance (SFA) recipients.

(1) For TANF/SFA, it is family violence when a recipient, or family member or household member has been subjected by another family member or household member as defined in RCW 26.50.010(2) to one of the following:

- (a) Physical acts that resulted in, or threatened to result in, physical injury;
- (b) Sexual abuse;
- (c) Sexual activity involving a dependent child;
- (d) Being forced as the caretaker relative or a dependent child to engage in nonconsensual sexual acts or activities;
- (e) Threats of or attempts at, physical sexual abuse;
- (f) Mental abuse;
- (g) Neglect or deprivation of medical care; or
- (h) Stalking.
- (2) DSHS shall:
- (a) Screen and identify TANF/SFA recipients for a history of family violence;
- (b) Notify TANF/SFA recipients about the family violence amendment both verbally and in writing;
- (c) Maintain confidentiality as stated in RCW 74.04.060;
- (d) Offer referral to social services or other resources for clients who meet the criteria in subsection (1) of this section;
- (e) Waive WorkFirst requirements that unfairly penalize victims of family violence, would make it more difficult to escape family violence or place victims at further risk. Requirements to be waived may include:

- (i) Time limits for TANF/SFA recipients, for as long as necessary (after fifty-two months of receiving TANF/SFA);
- (ii) Cooperation with the division of child support.
- (f) Develop specialized work activities for instances where participation in regular work activities would place the recipient at further risk of family violence.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-452-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-454 WAC

LIVING WITH A RELATIVE

WAC

388-454-0005	Living in the home of a relative or guardian requirement for TANF, SFA and GA-H.
388-454-0010	Definition of a parent or other relative for TANF and SFA.
388-454-0015	Temporary absence from the home.
388-454-0020	Temporary absence to attend school or training.
388-454-0025	Notice to parent when child lives with nonparental relative.

WAC 388-454-0005 Living in the home of a relative or guardian requirement for TANF, SFA and GA-H. (1) To be eligible for TANF or SFA, a child must live in the home of a parent or other relative as defined in WAC 388-454-0010.

(2) To be eligible for GA-H, a child must be living in the home of a person who is:

- (a) A court-appointed legal guardian or court-appointed custodian; and
- (b) Not a relative as defined in the TANF program.

(3) A home is defined as a family setting that is being maintained or is in the process of being established. A family setting exists when the relative or guardian assumes and continues to be responsible for the day to day care and control of the child. A family setting exists when a family is living in temporary shelter or has no shelter.

(4) A child or caretaker temporarily absent from the home remains eligible for assistance under the conditions described in WAC 388-454-0015 and 388-454-0020.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0010 Definition of a parent or other relative for TANF and SFA. To be eligible for TANF or SFA, a child must be living with a person who meets the following definition of a parent or relative.

(1) A child's parent is the child's natural or adoptive parent or a step-parent who is legally obligated to support the child.

(2) A man is considered to be a child's natural father if the relationship is:

- (a) Established under a judgment or order determining the parent and child relationship entered under RCW 26.26.130; or

(b) Presumed under the Uniform Parentage Act (RCW 26.26.040).

(3) Nonparental relatives include:

- (a) The following blood relatives (including those of half blood): siblings, first cousins (including first cousins once removed), nephews and nieces, and persons of preceding generations (including aunts, uncles and grandparents) as denoted by prefixes of great, great-great, or great-great-great;

(b) A natural parent whose parental rights have been terminated by a court order;

(c) A stepparent whose obligation to support the child has been terminated by the death of the child's natural or adoptive parent or the entry of a court order; and

(d) A step sibling even though the marriage of the step sibling's parent to the child's natural or adoptive parent is terminated by death, divorce or dissolution.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0015 Temporary absence from the home. The child or the caretaker is temporarily absent from the home as long as the caretaker continues to be responsible for the care and control of the child. Temporary absences cannot exceed ninety days except as described below. A caretaker must report a child's absence in excess of ninety days as required under WAC 388-418-0005. Temporary absences include:

(1) Receiving care in a hospital or public or private institution. If the temporary care exceeds ninety days, the assistance payment for the person is reduced to the CPI amount specified under chapter 388-478 WAC.

(2) Receiving care in a substance abuse treatment facility. If the care exceeds ninety days, the assistance payment for the person is reduced to the CPI amount specified under chapter 388-478 WAC.

(3) Visits in which the child or parent will be away for ninety days or less, including visits of a child to a parent who does not reside in the child's home.

(4) Placement of a child in foster care when the child's caretaker is receiving care in a residential treatment facility or for other reasons as determined by the division of children and family services (DCFS). DCFS must determine that the child is expected to return to the home within ninety days of the foster care placement.

(5) Placement of a child in foster care or in the temporary care of a relative, when:

(a) A parent or other relative applies for TANF or SFA on behalf of the child;

(b) DCFS has determined the child will be placed in the care of the applying relative within thirty days following the authorization of assistance; and

(c) No concurrent TANF or SFA payments are made for the child while in the temporary care of a relative.

(6) The child or caretaker is attending school or training as described in WAC 388-454-0020.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0020 Temporary absence to attend school or training. A child or caretaker is temporarily absent from the home to attend school or training when:

(1) The child's caretaker is attending a department approved vocational training program; or

(2) The child attends school or training away from home, as long as:

(a) The child returns to the family home during a year's period, at least for summer vacation; and

(b) The absence is necessary because:

(i) Isolation of the child's home makes it necessary for the child to be away to attend school;

(ii) The child is enrolled in an Indian boarding school administered through the Bureau of Indian Affairs; or

(iii) Specialized education or training is not available in the child's home community and is recommended by local school authorities.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-454-0025 Notice to parent when child lives with nonparental relative. (1) When TANF/SFA has been approved for a child who is living with a nonparental caretaker relative, the department will make reasonable efforts to notify the parent with whom the child most recently lived that:

(a) Assistance has been authorized for the child;

(b) Family reconciliation services may be requested from the department; and

(c) The parent has the right to request the child's address and location.

(2) The parent will be notified within seven calendar days of assistance authorization.

(3) The parent will not be notified if there is a substantiated claim that the parent has abused or neglected the child.

(4) Release of the child's address and location will be subject to the requirements of chapter 388-428 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-454-0025, filed 7/31/98, effective 9/1/98.]

Chapter 388-456 WAC

MONTHLY REPORTING

WAC

388-456-0001	Monthly reporting.
388-456-0005	Processing a late report.
388-456-0010	Recent work history.
388-456-0015	Exceptions to monthly reporting.

WAC 388-456-0001 Monthly reporting. (1) Monthly reporting requirements affect the following programs:

(a) TANF/SFA, and RCA cash assistance;

(b) GA-S;

(c) GA-H; and

(d) Food assistance program.

(2) Medical-only clients are not required to report monthly.

(3) Assistance units which must report the income and circumstances of all members monthly are:

(a) Those with earned income;

(b) Those with recent work history as defined in WAC 388-456-0010; and

(c) Those which have income allocated or deemed to them from persons with earned income who are financially responsible for a member of the assistance unit.

(4) Assistance units subject to monthly reporting must return a completed report on a form specified by the department.

(a) A report is considered complete when:

(i) All questions on the report are answered;

(ii) The report is signed; and

(iii) Income and changes are verified.

(b) The process month is the month following the month in which the income was received.

(5) Assistance units are notified when:

(a) Information or action is needed because the report is incomplete;

(b) The information reported changes the benefit amount or causes termination of benefits; or

(c) The report has not been received by the department. Assistance units are notified ten days in advance of the termination of cash and food assistance benefits. The effective date is the last day of the process month.

(6) When a food assistance unit is required to report monthly the requirements to report changes of circumstance in chapter 388-418 WAC do not apply.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-456-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-456-0005 Processing a late report. (1) A cash assistance unit can return a completed report before the end of the process month and receive reinstated benefits if information contained in the report establishes eligibility. The reinstated benefits are calculated to include work incentives.

(2) A food assistance unit can return a completed report before the end of the payment month and receive reinstated benefits if information contained in the report establishes eligibility.

(3) Cash and food assistance units will be notified of:

(a) The new benefit amount; or

(b) The termination of benefits and the reason if information contained in the report causes the termination of benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-456-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-456-0010 Recent work history. Recent work history means that the assistance unit has had employment in one of the two months prior to the payment month as defined in WAC 388-450-0240.

(1) Newly approved assistance units with recent work history must report income and circumstances monthly for two months beginning with the month following their approval for assistance.

(2) Recipient assistance units who report that their earned income has stopped must continue to report monthly for two months after the last receipt of income from employment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-456-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-456-0015 Exceptions to monthly reporting. The following assistance units with earned income or recent work history are exempt from monthly reporting:

(1) Migrant assistance units as defined in WAC 388-450-0215;

(2) Homeless assistance units as defined in WAC 388-408-0050;

(3) Assistance units with a recent work history in which all adult members are:

(a) Elderly as defined in WAC 388-404-0015; or

(b) Disabled as defined in WAC 388-400-0040; or

(4) Assistance units whose sole income is from college work study issued from either:

(a) Title IV of the Higher Education Amendments; or

(b) Bureau of Indian Affairs student assistance programs; and

(5) For food assistance programs only, seasonal farm worker assistance units as defined in WAC 388-450-0216.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-456-0015, filed 7/31/98, effective 9/1/98.]

Chapter 388-458 WAC NOTICES TO CLIENTS

WAC

388-458-0005 Adequate notice of denial or withdrawal.

388-458-0010 Adequate notice of adverse action to recipients.

388-458-0015 Translation of written communications with limited English proficient clients.

WAC 388-458-0005 Adequate notice of denial or withdrawal. (1) When a client's application for cash, medical or food assistance is denied or withdrawn, the client receives a written notice of denial or withdrawal which includes:

(a) The reason or reasons for the denial or withdrawal and the rules to support the department's decision;

(b) The date of the decision; and

(c) The right to a fair hearing.

(2) When the applicant does not provide requested information and there is not enough information available for the department to determine eligibility, the denial notice also includes:

(a) A description of the information that was requested and not provided, including the date the information was requested;

(b) A statement that eligibility for assistance cannot be established based on information available to the department; and

(c) That eligibility will be redetermined if, within thirty days from the date of the denial notice, the applicant:

(i) Provides all specified information previously requested but not provided; and

(ii) The applicant's circumstances have not changed.

(3) Notice of a decision to deny or withdraw an application must be provided as required under chapter 388-406 WAC.

(4) Notices to clients who qualify for necessary supplemental accommodation services will be provided as required under WAC 388-200-1300.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-458-0010 Adequate notice of adverse action to recipients. An adequate written notice of a decision to terminate, suspend, reduce or restrict cash, medical or food assistance benefits includes a statement of:

(1) The action the department intends to take;

(2) The reasons for the intended action;

(3) The specific rule, regulation or law supporting the action;

(4) The recipient's right to request a fair hearing, including the circumstances under which assistance may be continued if a hearing is requested;

(5) Timely notice of a decision to terminate, suspend, or reduce assistance must be provided as required under WAC 388-418-0030; and

(6) Notices to clients who qualify for necessary supplemental accommodation services will be provided as required under WAC 388-200-1300.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0010, filed 7/31/98, effective 9/1/98. Formerly WAC 388-525-2520.]

WAC 388-458-0015 Translation of written communications with limited English proficient clients. The following written communications concerning cash, medical and food assistance programs are translated into the primary language of clients with limited English proficiency:

(1) Notices requesting information or action which require a response from the client to determine:

(a) Initial eligibility; or

(b) Continuing eligibility for assistance.

(2) Notices of approval, denial, or withdrawal of applications for assistance;

(3) Notices of termination, suspension, reduction or restriction of assistance;

(4) Notices describing client rights and responsibilities;

(5) Notices requiring a client's signature or informed consent; and

(6) Notice of overpayments of cash, medical and food assistance.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-458-0015, filed 7/31/98, effective 9/1/98.]

Chapter 388-460 WAC PAYEES ON BENEFIT ISSUANCES

WAC

388-460-0001	Payee for cash, medical and food assistance benefits.
388-460-0005	Authorized representative for food assistance benefits.
388-460-0010	Food assistance authorized representative—Treatment centers and group homes.
388-460-0015	Persons who may not be an authorized representative for a food assistance unit.

WAC 388-460-0001 Payee for cash, medical and food assistance benefits. (1) Cash assistance may be issued in the name of the following persons:

(a) A client who is the recipient of the benefits;

(b) An ineligible parent or other relative receiving benefits on behalf of an eligible child;

(c) A person, facility, organization, institution or agency acting as a protective payee or representative payee for a client;

(d) A guardian or agent acting on behalf of a client; or

(e) A vendor of goods or services supplied to an eligible client.

(2) When medical coverage accompanies cash assistance, the medical identification (MAID) card for the assistance unit members is issued in the name of the person listed as payee for the cash benefit.

(1999 Ed.)

(3) For other medical assistance units, the MAID card is issued to the person named as the head of the assistance unit.

(4) Food assistance benefits are issued to the person named as the head of the food assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0005 Authorized representative for food assistance benefits. An authorized representative is an adult who is not a member of the food assistance unit but has the knowledge and consent of the assistance unit to act on their behalf.

(1) A responsible member of the food assistance unit can name, in writing, an authorized representative. An authorized representative has authority to:

(a) Apply for food assistance on behalf of the food assistance unit;

(b) Redeem the food coupon authorization (FCA) card for the unit; and

(c) Purchase food for the food assistance unit using the unit's authorized benefit allotment.

(2) A responsible member of the food assistance unit can name, in writing, an emergency authorized representative to transact a particular FCA card when no responsible member is able to transact the card. Both the responsible member of the food assistance unit and the person named must sign the written statement.

(3) The food assistance unit members are liable for any over-issuance that may result from information supplied to the department by the authorized representative.

(4) An authorized representative may act on behalf of more than one food assistance unit when approved by the CSO administrator.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0010 Food assistance authorized representative—Treatment centers and group homes. (1) Residents in group homes may choose to have food assistance benefits authorized as follows:

(a) On their own behalf;

(b) Through an authorized representative of their choosing; or

(c) Through a facility acting as authorized representative.

(2) Residents in chemical dependency treatment centers are required to have a designated employee of the facility act as an authorized representative.

(3) The authorized representative for residents in a chemical dependency treatment center or a group home must:

(a) Be aware of the resident's circumstances;

(b) Notify the department of any changes in income, resources or circumstances within ten days of the change;

(c) Use the resident's food assistance benefit allotment for meals served to the resident; and

(d) Maintain enough benefits in the facility electronic benefits transfer (EBT) account to allow the department to transfer one-half of a client's monthly allotment to the client's own account. The client is entitled to one-half of the

food assistance benefits when the client leaves the facility on or before the fifteenth of the month.

(4) When assigning an employee as the authorized representative for residents, a facility accepts responsibility for:

(a) Any misrepresentation or intentional program violation; and

(b) Liability for food assistance benefits held at the facility on behalf of the resident.

[Statutory Authority: RCW 74.04.510, 74.08.090, 74.04.055, 74.04.057 and S. 825, Public Law 104-193, Personal Responsibility and Work Opportunity Reconciliation Act of 1996. 99-02-039, § 388-460-0010, filed 12/31/98, effective 1/31/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-460-0015 Persons who may not be an authorized representative for a food assistance unit. (1) A person acting as an authorized representative for a food assistance unit will be disqualified for one year when that person:

(a) Knowingly provides false information to the department;

(b) Misrepresents the food assistance unit's circumstances; or

(c) Misuses the food assistance benefits.

(2) The authorized representative and the head of the food assistance unit are notified thirty days prior to the disqualification taking effect.

(3) The following persons may act as an authorized representative for a food assistance unit only with written approval of the CSO administrator and only when no one else is available:

(a) An employee of the department;

(b) Any person disqualified from the food assistance program because of an intentional program violation;

(c) A retailer authorized to accept coupons;

(4) A public or private nonprofit organization providing meals for homeless persons may not be an authorized representative under any conditions.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-460-0015, filed 7/31/98, effective 9/1/98.]

Chapter 388-462 WAC PREGNANCY

WAC

388-462-0005 Pregnancy requirement for GA-S.

388-462-0010 Pregnancy requirement for TANF and SFA.

388-462-0015 Medical programs for pregnant women.

WAC 388-462-0005 Pregnancy requirement for GA-S. (1) A woman may be eligible for GA-S at any stage of pregnancy if:

(a) The pregnancy is medically verified; and

(b) She meets the requirements of WAC 388-400-0020.

(2) A woman is eligible for GA-S until the end of the month containing the last day of the six week period following the child's birth if:

(a) She relinquishes the child for adoption; and

(b) She was receiving:

(i) GA-S at the time of the child's birth; or

(ii) TANF at the time of the child's birth and later becomes ineligible for TANF because no eligible child resides in the home.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-462-0010 Pregnancy requirement for TANF and SFA. A woman who is not a caretaker relative of a TANF or SFA eligible child may be eligible for TANF or SFA if:

(1) She is in the third trimester of pregnancy (the three calendar months preceding the expected month of birth) as medically verified; and

(2) The unborn, if born and living with the woman in the month of payment, would be deprived of parental support and care as defined in chapter 388-430 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-462-0015 Medical programs for pregnant women. (1) A pregnant woman is eligible for medical services described in this chapter only when her pregnancy is confirmed by a licensed medical practitioner, licensed laboratory, community clinic, family planning clinic, or health department clinic.

(2) A pregnant woman is eligible for CN medical coverage if she meets the following requirements as described in WAC 388-503-0505:

(a) Citizenship or immigration status (chapter 388-424 WAC); and

(b) Social Security Account Number (chapter 388-474 WAC); and

(c) Washington state residence (chapter 388-468 WAC); and

(d) Countable income meets the standard described in WAC 388-478-0075.

(3) A pregnant woman is considered for medically needy (MN) program coverage if she meets the requirements in subsection (2)(a) through (c) of this section and:

(a) Her countable income is greater than the standard in subsection (2)(d) of this section; and

(b) Her countable resources do not exceed the standard in WAC 388-478-0070.

(4) A pregnant woman is eligible for CN scope of care under the state-funded pregnant woman program if she is not eligible for programs in subsection (2) of this section due to citizenship, immigrant or Social Security Number requirements.

(5) A pregnant woman is considered for MN scope of care under the state-funded pregnant woman program if:

(a) She is not eligible for the program under subsection (4) of this section because her income exceeds the standard; and

(b) Her resources do not exceed the standard in WAC 388-478-0070.

(6) A pregnant woman is considered for the medically indigent (MI) program if her resources exceed the standards in WAC 388-478-0070.

(7) Only the income of an unmarried father of an unborn actually contributed to a pregnant woman is considered as income to her.

(8) There are no resource limits for the programs described in subsections (2) and (4) of this section.

(9) The assignment of child support and medical support rights as described in chapter 388-422 WAC do not apply to pregnant women.

(10) Unless stated otherwise, this section contains the only eligibility requirements for pregnant women to qualify for medical coverage.

(11) A woman who was eligible for and received medical on the last day of pregnancy is eligible for extended medical benefits for postpartum care through the end of the month:

(a) Which includes the sixtieth day from the end of the pregnancy, for a pregnant woman receiving Medical in any program except Medically Indigent (MI); or

(b) The pregnancy ends, for a pregnant woman receiving MI benefits.

(12) A woman who was eligible for a medical program on the last day of pregnancy is eligible for family planning services for twelve months from the end of the pregnancy.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-462-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-508-0820, 388-508-0830, 388-522-2230 and 388-508-0835.]

Chapter 388-464 WAC QUALITY ASSURANCE

WAC

388-464-0001 Requirement to cooperate with quality assurance.

WAC 388-464-0001 Requirement to cooperate with quality assurance. (1) To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or federal food stamp benefits, the following clients are required to cooperate in the quality assurance review process:

(a) All adult recipients or payees in a TANF or SFA assistance unit; or

(b) All household members in a food assistance unit.

(2) Assistance units become ineligible for benefits upon a determination of noncooperation by quality assurance and remain ineligible until the client meets quality assurance requirements or:

(a) For TANF/SFA clients, one hundred twenty days from the end of the annual quality assurance review period; or

(b) For food assistance household members, ninety-five days from the end of the annual quality assurance review period.

(3) The quality assurance review period covers the federal fiscal year which runs from October 1st of one calendar year through September 30th of the following year.

(4) Individuals reapplying for TANF, SFA, or federal food stamps after the sanction period has ended must provide verification of all eligibility requirements. However, individuals meeting expedited service criteria only need to provide expedited service verification requirements.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-464-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-466 WAC REFUGEE PROGRAM

WAC

388-466-0005	Immigration status requirement for refugee assistance.
388-466-0010	Treatment of income and resources for refugee assistance.
388-466-0015	Work and training requirements for refugee cash assistance.
388-466-0020	Exemptions to work and training requirements.
388-466-0025	Penalties for not complying with work and training requirements.

WAC 388-466-0005 Immigration status requirement for refugee assistance. (1) To be eligible for refugee cash assistance (RCA) and refugee medical assistance (RMA), a person must prove, by providing documentation issued by the Immigration and Naturalization Service (INS), that he or she was:

(a) Admitted as a refugee under section 207 of the Immigration and Nationalities Act (INA);

(b) Paroled into the U.S. as a refugee or asylee under section 212 (d)(5) of the INA;

(c) Granted conditional entry under section 203 (a)(7) of the INA;

(d) Granted asylum under section 208 of the INA;

(e) Admitted as an Amerasian Immigrant from Vietnam through the orderly departure program, under section 584 of the Foreign Operations Appropriations Act, incorporated in the FY88 Continuing Resolution P.L. 100-212;

(f) A Cuban-Haitian entrant who was admitted as a public interest parolee under section 212 (d)(5) of the INA.

(2) A permanent resident alien meets the immigration status requirements for RCA and RMA if the individual was previously in one of the statuses described in subsections (1)(a) through (f) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-466-0010 Treatment of income and resources for refugee assistance. The income and resources of refugee cash assistance and refugee medical assistance (RCA/RMA) clients are treated according to the rules for the TANF program in chapters 388-450 and 388-470 WAC, except that RCA/RMA clients do not qualify for:

(1) The fifty percent work incentive allowed under WAC 388-450-0190. Instead, the first ninety dollars of an RCA/RMA client's monthly gross earned income is disregarded;

(2) The three thousand dollars savings account exclusion allowed to recipients under WAC 388-470-0050;

(3) The exclusion of a motor vehicle used to transport a physically disabled household member under WAC 388-470-0070; and

(4) The five thousand dollars vehicle equity value exclusion in WAC 388-470-0070. Instead, the equity value exclusion for a vehicle owned by an RCA/RMA client is fifteen hundred dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-466-0015 Work and training requirements for refugee cash assistance. To be eligible for refugee cash assistance, clients must meet the following work and training requirements unless they are exempt from participation under WAC 388-466-0020:

(1) Register for employment with the employment security department or other employment agency designated by the department.

(2) Enroll and participate in department-approved employability training programs. Training means available and appropriate programs which:

(a) Provide job or language training as approved in the client's personal employment plan; and

(b) Are intended to have a definite (less than one year) employment objective.

(3) Accept appropriate offers of employment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-466-0020 Exemptions to work and training requirements. (1) Clients are exempt from refugee cash assistance work and training requirements when they are:

(a) Fifteen years of age or younger;

(b) Eighteen years of age or younger and enrolled full-time in high school or vocational/technical training and reasonably expected to complete the program before reaching nineteen years of age;

(c) Sixty-five years of age or older;

(d) Suffering from an illness or injury that is serious enough to temporarily prevent participation in work or training;

(e) Incapacitated as determined by a physician or licensed psychologist;

(f) Needed in the home as the primary care provider for an ill, injured, or incapacitated household member;

(g) A single parent or other caretaker relative of a child five years of age or younger;

(h) A parent or other caretaker of a child when a nonexempt spouse or other nonexempt adult relative in the home is meeting work and training requirements; or

(i) Employed at least thirty hours per week.

(2) A person is not exempt from work and training requirements solely because of an inability to communicate in English.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0020, filed 7/31/98, effective 9/1/98.]

WAC 388-466-0025 Penalties for not complying with work and training requirements. (1) A person who is not exempt from the work and training requirements of WAC 388-466-0015 is not eligible for refugee cash assistance if he or she is:

(a) An applicant who:

(i) Has voluntarily quit employment or refused an offer of employment or a training opportunity within the past thirty days, unless there was good cause to quit or refuse the employment or training under WAC 388-55-027; or

(ii) Is a former recipient who applies during a period of ineligibility established under subsection (2) of this section; or

(b) A recipient who, without good cause as defined under WAC 388-55-027:

(i) Voluntarily quits employment; or

(ii) Fails or refuses to comply with the work and training requirements of WAC 388-466-0015(2).

(2) Assistance to a recipient who is ineligible under subsection (1)(b) of this section will be terminated after the recipient is provided with advance and adequate notice:

(a) Assistance will not be terminated if, during the advance notice period, the recipient:

(i) Decides to accept employment or to participate in required training at any time before the date of termination; and

(ii) Is otherwise eligible for assistance.

(b) If the recipient does not accept employment or does not participate in required training before the date of termination, he or she will be ineligible for a period of:

(i) Three months from the date of termination after the first occurrence; or

(ii) Five months from the date of termination after the second occurrence.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-466-0025, filed 7/31/98, effective 9/1/98.]

Chapter 388-468 WAC

RESIDENCY

WAC

388-468-0005 Residency.

WAC 388-468-0005 Residency. (1) A resident is an individual who:

(a) Currently lives in Washington and intends to continue living here; or

(b) Entered the state looking for a job; or

(c) Entered the state with a job commitment.

(2) A person does not need to live in the state for a specific period of time to be considered a resident.

(3) With the exception of subsection (4) of this section, a client can temporarily be out of the state for more than one month. If so, they must supply the department with adequate information to demonstrate their intent to continue to reside in the state of Washington.

(4) Noncategorically eligible food assistance households remaining out of the state more than one calendar month lose their state residence status.

(5) Residency is not a requirement for the following:

(a) The medically indigent (MI) program; or

(b) Detoxification services.

(6) It is not necessary for a person moving from another state directly to a nursing facility in Washington state to establish residency, prior to entering the facility.

(7) A person who enters Washington state temporarily just to get medical care does not meet the definition of a resident and is not eligible for those services.

(8) For purposes of medical programs a client's residence is the state:

(a) Making a state Supplemental Security Income (SSI) payment; or

(b) Making federal payments for foster or adoption assistance under Title IV-E of the Social Security Act; or

(c) Of residence of the parent or legal guardian, if appointed, for an institutionalized:

(i) Minor child; or

(ii) Client twenty-one years of age or older, who became incapable of determining residential intent before reaching age twenty-one.

(d) Where a client is residing if the person becomes incapable before reaching twenty-one years of age; or

(e) Making a placement in an out-of-state institution.

(9) In a dispute between states as to which is a person's state of residence, the state of residence is the state in which the person is physically located.

(10) A former resident of the state can apply for the GA-U program while living in another state if:

(a) The person:

(i) Plans to return to this state; and

(ii) Intends to maintain a residence in this state; and

(iii) Lives in the United States at the time of the application.

(b) In addition to the conditions in subsection (10)(i), (ii), and (iii) being met, the absence must be the result of one of the following:

(i) Is enforced and beyond the person's control; or

(ii) Is essential to the person's welfare and is due to physical or social needs.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-468-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-470 WAC

RESOURCES

WAC

388-470-0005	Resource eligibility and limits.
388-470-0010	How to determine who owns a resource.
388-470-0015	Availability of resources.
388-470-0020	Excluded resources.
388-470-0025	Excluded resources.
388-470-0030	Excluding a home as a resource.
388-470-0035	Excluded resources for food assistance.
388-470-0040	Additional excluded resources for SSI-related medical assistance.
388-470-0045	Resources that are counted toward the resource limits for cash, food assistance and TANF-related medical programs.
388-470-0050	Resources that count.
388-470-0055	Resources that are counted for food assistance.
388-470-0060	Resources of an alien's sponsor.
388-470-0065	Individual development accounts for TANF recipients.
388-470-0070	How vehicles are counted toward the resource limit for cash assistance and TANF/SFA-related medical.
388-470-0075	How vehicles are counted for food assistance.
388-470-0080	Compensatory award or related settlement lump sum payments.

WAC 388-470-0005 Resource eligibility and limits.

(1) A resource is personal property or real property or certain types of payments that are not considered income that is owned by and available to a client.

(2) A client may own and keep excluded resources or countable resources up to the resource limit.

(3) For SSI-related medical a resource is considered available when the client or spouse:

(a) Owns the resource; and
 (b) Has the authority to convert the resource to cash; and
 (c) Is not legally restricted from using the resource for the person's support and maintenance.

(4) For an SSI-related client a resource is available on the first day of the month following receipt of the resource.

(5) Available resources may be:

(a) Excluded which means it is not counted toward the resource limit;

(b) Partially excluded:

(i) The resource is not counted up to a specified dollar amount; but

(ii) Any amount over that amount is counted toward the resource limit; or

(c) Countable which means the entire value is counted toward the resource limit.

(6) For medical programs, if the household consists of more than one medical assistance unit (MAU), the resources for each MAU are considered according to the related program.

(7) An assistance unit's resources are determined by:

(a) Disregarding all excluded resources;

(b) Adding the value of:

(i) Resources that are in excess of the excluded dollar amounts; and

(ii) Resources that are countable; and

(c) Comparing the total countable resources to the applicable resource limit for the assistance unit;

(d) If the total resources exceed the applicable resource limit, the assistance unit's benefits are denied or terminated except for institutional medical programs as described in WAC 388-513-1395.

(8) The value of a resource is the equity value. The equity value is the amount a person could receive for the resource (fair market value) minus the legal amount still owing. Limits for countable resources are:

(a) For cash assistance and TANF-related medical, an eligible assistance unit's countable resources must be at or below one thousand dollars;

(b) For food assistance, an eligible assistance unit's countable resources must be at or below:

(i) Three thousand dollars for any household with an elderly member; or

(ii) Two thousand dollars for all other households.

(9) For food assistance, assistance units in which all members are receiving cash assistance or SSI do not have to meet the resource limits in subsection (8)(b) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0010 How to determine who owns a resource. Unless specifically stated, this section applies to all cash, TANF-related medical and food assistance programs.

(1) A client owns a resource when the client holds the title to real or personal property or has possession of the property but there is no title.

(2) A client may provide evidence to clarify ownership when doubt exists about:

(a) Ownership (full or partial);

(b) Legal control; or

(c) Value.

(3) Community property is an available resource unless the client can provide proof to the contrary.

(4) Real or personal property is considered to be community property when it is in the name of either the husband or wife or both and can be disposed of by either of them.

(5) For cash assistance, community property owned by the husband or wife or both will be used to determine eligibility for the assistance unit, regardless that one or both are clients.

(6) Resources are considered separate property rather than community property when the property was:

(a) Acquired and paid for by either spouse before marriage;

(b) Acquired and paid for entirely out of income from separate property; or

(c) Received by one of the spouses as a gift or inheritance.

(7) Property is no longer considered separate when both community and separate properties are used to purchase or improve real or personal property.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0015 Availability of resources. (1) A resource is considered available when a cash, TANF/SFA-related medical or food assistance program client has:

(a) Actual title;

(b) Control over and can legally dispose of it; and

(c) The ability to transfer it to a buyer or convert it into cash.

(2) Only resources that are actually available will affect eligibility. However, for cash assistance only, the client must take reasonable action to make the resource available.

(3) A client may provide evidence that a resource is unavailable.

(4) For medical programs a resource is considered unavailable when the client or spouse:

(a) Does not own the resource;

(b) Does not have the authority to convert the resource to cash;

(c) Is legally restricted from using the resources for the person's support and maintenance;

(d) Cannot convert the resource to cash within twenty work days; and

(e) Makes a reasonable effort to convert noncash resources to cash.

(5) Resources of persons residing in a shelter for battered women and children are not considered available when:

(a) The resource is owned jointly with members of the former household; and

(b) Availability of the resource depends on an agreement of the joint owner.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-507-0730.]

WAC 388-470-0020 Excluded resources. Resources that do not count toward a cash, medical or food assistance client's resource limit are:

[Title 388 WAC—p. 596]

(1) Burial plot:

(a) For cash assistance and TANF/SFA-related medical programs other than SSI-related, one burial plot for each assistance unit member is excluded.

(b) For food assistance, one burial plot for each assistance unit member including ineligible members is excluded.

(c) For SSI-related medical the limits are described in WAC 388-470-0040 (14) and (15).

(2) Energy assistance payments;

(3) Household goods such as furniture;

(4) Noncash Resources are excluded for categorically needy (CN) and medically needy (MN) medical programs when the client:

(a) Cannot convert the noncash resource to cash within twenty work days; and

(b) Makes an ongoing attempt to convert the noncash resources to cash.

(5) Personal items such as clothing is excluded. For cash assistance programs, personal property of "great sentimental value" can be excluded due to personal attachment or hobby interest, without consideration to its value;

(6) The value of a sales contract is excluded for TANF-related medical. Sales contracts for SSI-related medical are described in WAC 388-470-0040;

(7) Resources excluded by federal law;

(8) Trust accounts when not available to the assistance unit except as specified in WAC 388-470-0015(2).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580.]

WAC 388-470-0025 Excluded resources. The following resources do not count toward the resource limits:

(1) Adoption support payments when the adopted child is excluded from the assistance unit.

(2) Bona fide loans which means the loan is a debt a client owes and has an obligation to repay.

(3) Earned income tax credit in the month received and the following month.

(4) For cash assistance only, excess real property on which a client is not living:

(a) When, for a period not to exceed nine months, a client:

(i) Makes a good-faith effort to sell the excess property; and

(ii) Signs an agreement to repay the amount of benefits received or the net proceeds of the sale, whichever is less.

(b) Upon cash assistance approval, the agreement to repay is sent to office of financial recovery to file a lien without a specified amount; or

(c) Is used in a self-employment enterprise and meets the criteria in subsection (10) of this section.

(5) Food coupon allotment from the food assistance programs.

(6) Food service payments provided for children under the National School Lunch Act of 1966, PL 92-433 and 93-150.

(7) Foster care payments provided under Title IV-E, State or Local foster care maintenance payments.

(1999 Ed.)

(8) Housing and Urban Development (HUD) community development block grant funds.

(9) Income tax refunds are excluded in the month the refund is received.

(10) A bank account jointly owned with an SSI recipient when SSA counted the funds to determine the SSI recipient's eligibility.

(11) Real and personal property used in a self-employment enterprise if:

(a) The property is necessary to restore the client's independence or will aid in rehabilitating the client or the client's dependents; and

(b) The client has signed an agreed plan with the department.

(12) Retroactive cash benefits or TANF benefits resulting from a court order modifying a department policy.

(13) Self-employment-accounts receivable that a client bills to the client's customer but has been unable to collect.

(14) SSI recipient's income and resources.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0030 Excluding a home as a resource.

(1) For cash and TANF-related medical assistance programs a home with a reasonable amount of surrounding property is excluded when the home is owned and used as a resident by the client or the client's dependents.

(2) If a client and his or her dependents are absent from the home for more than ninety consecutive days, the total value of the home will count toward the resource limit, unless the absence is due to:

- (a) Hospitalization; or
- (b) Other health reasons; or
- (c) A natural disaster.

(3) If the absence is due to hospitalization or other health reasons the client may be absent for more than ninety days and continue to have the home excluded as a resource when:

(a) At least one of three physicians provides a written statement that in their medical opinion, the client can return to the home during the client's lifetime; or

(b) The home continues to be occupied by a spouse or dependent children or children with disabilities.

(4) If the absence is due to a natural disaster the client may be absent for more than ninety days and continue to have the home excluded as a resource when:

(a) The home is not fit to live in; and

(b) The home will become fit to live in with reasonable effort and expense to the client.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0035 Excluded resources for food assistance. The following resources do not count toward a client's resource limit.

(1) Earned income tax credit is excluded:

(a) In the month it is received and the following month if the person was not a food assistance recipient when the credit was received; or

(b) For twelve months when the person:

(i) Was a food assistance recipient when the credit was received; and

(ii) Remains a food assistance recipient continuously during this period.

(2) Essential property needed for employment or self-employment of a household member is excluded. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing.

(3) Excluded funds that are deposited in a bank account with countable funds continue to be excluded up to six months from the date of deposit.

(4) Governmental disaster payments to repair a damaged home when the household can be sanctioned if the funds are not used for this purpose.

(5) A home a client is living in including the surrounding property that is not separated by property owned by others is excluded. Public right of ways do not affect this exclusion;

(6) A home that the household is not living in and surrounding property is excluded if the household:

(a) Is making a good faith effort to sell; or

(b) Is planning to return to the home and it is not occupied due to:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Unlivable conditions caused by a natural disaster or casualty.

(7) Indian lands that are held jointly by the tribe or can be sold only with the approval from the Bureau of Indian Affairs (BIA) are excluded;

(8) Installment contracts:

(a) Installment contracts or agreements for the sale of land or property are excluded when they are producing income consistent with their fair market value;

(b) Value of property sold under an installment contract or held for security is excluded if the purchase price is consistent with fair market value.

(9) Insurance policies and pension funds:

(a) Cash value of life insurance policies and pension funds (excluding IRAs and Keogh Plans) are excluded.

(b) Prepaid burial plans are excluded when the plan:

(i) Is death insurance as opposed to a bank account; and

(ii) Requires repayment for allowable withdrawals.

(10) Land. Where a client plans to build a permanent home or is excluded where their property is not separated by land owned by others. The land is countable if the assistance unit owns another home.

(11) A resource is excluded when it is owned by an assistance unit member who receives TANF/SFA or SSI.

(12) Resources that are owned by persons who are not members of the household are excluded.

(13) A resource is excluded when, if it is sold, would only result in a gain to the household of one-half of the applicable resource limit as defined under WAC 388-470-0005. The resource must be something other than stocks, bonds, negotiable financial instruments, or a vehicle.

(14) Prorated income for self-employed persons or ineligible students. These monies retain their exclusion for the

period of time the income is prorated even when commingled with other funds.

(15) Real or personal property when:

- (a) It produces yearly income that is equal to its fair market value even when used only on a seasonal basis;
- (b) Secured by a lien for a business loan and the lien prevents the household from selling it; or
- (c) It is directly related to the maintenance or use of a vehicle excluded in WAC 388-470-0075.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0040 Additional excluded resources for SSI-related medical assistance. In addition to other SSI-related resource exclusions in this chapter the resources in this section are excluded when a client's eligibility for SSI-related medical assistance is determined.

(1) A client's household goods and personal effects are excluded.

(2) One home, which may be any shelter in which the client has ownership interest, is excluded when:

(a) The client uses the home as the principal place of residence;

(b) The client's spouse resides in the home; or

(c) The client does not currently live in the home and the client:

(i) Intends to return to the home; and

(ii) Provides the department with an oral or written statement of their intent to return; or

(d) A relative resides in the home when:

(i) The relative is financially or medically dependent on the client; and

(ii) The client or dependent relative provides the department with a written statement of the dependency.

(3) Proceeds, including cash or a sales contract, from the sale of the home described in subsection (2) of this section are excluded when the client purchases another home within three months of receipt of the proceeds of the sale. Only the portion of the sales contract payment which represents interest is counted as unearned income. See WAC 388-450-0040.

(4) The value of a sales contract is excluded:

(a) When the current market value of the contract is zero or the contract is unsalable; or

(b) When combined with other resources, it exceeds the resource limit, and the sales contract was executed:

(i) On or before November 30, 1993; or

(ii) On or after December 1, 1993, and:

(A) Was received as compensation for the sale of the client's principle place of residence;

(B) Provides interest within the prevailing interest rate at the time of the sale;

(C) Requires the repayment of a principal amount equal to the fair market value of the property; and

(D) Payment on the amount owed does not exceed thirty years.

The income a client receives which represents the principle and interest portion of a sales contract meeting the definition of this subsection is counted as unearned income. See WAC 388-450-0040.

(5) A sales contract is a nonexcluded resource when:

- (a) It does not meet the conditions in subsection (4); or
- (b) The client transferred it to someone other than the client's spouse. See WAC 388-513-1365.

(6) When a client owns a sales contract as described in subsection (5), the portion of the payment which represents the:

- (a) Principle is counted as an available resource; and
- (b) Interest is counted as unearned income.

(7) The equity value of one vehicle up to five thousand dollar is excluded. The five thousand dollars limitation does not apply when the client or a member of the client's household, uses the vehicle which is:

(a) Necessary for employment; or

(b) Necessary for the treatment of specific or regular medical problem; or

(c) Modified for operation by, or transportation of, a person with disabilities; or

(d) Necessary due to climate, terrain, distance, or similar factors to provide the client transportation to perform essential daily activities.

(8) Property which is essential to self-support is excluded when:

(a) The client uses the property for an income producing activity:

(i) In a trade or business; or

(ii) As an employee for work.

(b) The client uses nonbusiness property with a value up to six thousand dollars in equity, to produce:

(i) Goods or services essential to daily activities, solely for the client's household;

(ii) An annual income return of six percent or more of the exempt equity; or

(iii) A six percent return within a twenty-month period when the client uses the property, or is expected to resume using the property within twelve months, for the activities described in this subsection.

(9) Resources necessary for a client, who is blind or disabled, to enable them to fulfill an approved self-sufficiency plan are excluded.

(10) Alaska Native Claims Settlement Act benefits are excluded, including:

(a) Shares of stock held in a regional or village corporation;

(b) Cash or dividends on stock received from a native corporation up to two thousand dollars per person per year;

(c) Stock issued by a native corporation as a dividend;

(d) A partnership interest;

(e) Land or an interest in land; and

(f) An interest in a settlement trust.

(11) The total cash surrender value (CSV) of a life insurance policy or policies when the total face value of all policies held by the client is fifteen hundred dollars or less are not counted. The CSV of a client's policies in excess of fifteen hundred dollars is applied to the client's resource limit as described in WAC 388-478-0070 and 388-478-0080.

(12) Restricted allotted land owned by an enrolled tribal member and spouse, if the land cannot be disposed of without the permission of the other person, the tribe, or an agency of the federal government is not counted.

(13) A settlement the client receives for the purpose of repairing or replacing a specific excluded resource is not counted for a period of:

(a) Nine months when the client uses the total amount of the cash to repair or replace the excluded resource;

(b) Nine additional months when:

(i) Circumstances beyond the control of the client prevent the repair or replacement of the excluded resource; and

(ii) The client uses the total amount of the cash to repair or replace the excluded resource.

(c) Twelve additional months, for a maximum of thirty months, when:

(i) The settlement is a result of a catastrophe which is declared a major disaster by the President of the United States;

(ii) The excluded resource is geographically within the disaster area as defined by the presidential order;

(iii) The client intends to repair or replace the excluded resource; and

(iv) Circumstances beyond the control of the client prevented the repair or replacement of the excluded resource in the time frames described under subsection (13)(a) and (b) of this section.

(d) Except, any settlement excluded and not used within the allowable time period as described under this subsection as an available resource.

(14) Burial spaces for the client and any member of the client's immediate family, as described in subsection (16) are not counted. Burial spaces include:

(a) Conventional grave sites;

(b) Crypts;

(c) Mausoleums; or

(d) Urns and other repositories customarily used for the remains of deceased persons.

(15) A burial space purchase agreement is also defined as a burial space. The value of the purchase agreement is excluded, as well as any interest accrued on the purchase agreement, which is left to accumulate as part of the value of the burial space purchase agreement.

(16) Immediate family, for purposes of subsection (14) of this section includes the client's:

(a) Spouse;

(b) Minor and adult children, including adopted and stepchildren;

(c) Siblings;

(d) Parents and adoptive parents;

(e) Spouses of any of the above.

None of the family members listed above need to be dependent upon or living with the client, to be considered immediate family members.

(17) The following types of burial funds are excluded as resources:

(a) Up to fifteen hundred dollars each for a client or a client's spouse when funds are specifically set aside solely for burial expenses;

(b) A revocable burial contract, burial trust, cash, account, or other financial instrument with a definite cash value; and

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(c) Any interest earned and appreciation in the value of excluded burial funds when left to accumulate and become part of the burial fund.

(18) Funds which a client has specifically set aside solely for burial expenses, as described in subsection (17) of this section are funds which:

(a) Are kept separate from all other resources except nonexcluded funds the client intends to use solely for burial related items or services and identified as a burial fund; and

(b) May be designated as burial funds back to the first day of the month in which the person intended the funds to be set aside for burial.

(19) The limitation described under subsection (17)(a) of this section is reduced by:

(a) The face value of insurance policies owned by the client or spouse if the policies have been excluded as provided in subsection (11) of this section; and

(b) Amounts in an irrevocable burial trust.

(20) A client's burial funds lose excluded status when:

(a) They are mixed with other resources; or

(b) The burial funds, interest, or appreciated values are used for other purposes. These funds are then considered available income:

(i) On the first of the month of use; if

(ii) When added to other nonexcluded resources, the amount exceeds the resource limit as described in WAC 388-478-0080.

(21) All resources specifically excluded by federal statute are not counted.

(22) Retroactive SSI payments, including benefits a client receives under the interim assistance reimbursement agreement with the Social Security Administration, or Social Security Disability Insurance (OASDI) payments are excluded for six months following the month of receipt. This exclusion applies to:

(a) Payments received by the client, spouse, or any other person the client is financially responsible for;

(b) SSI payments made to the client for benefits due for a month before the month of payment;

(c) OASDI payments made to the client for benefits due for a month that is two or more months before the month of payment; and

(d) Payments held as cash, in a checking account, or in a saving account. This exclusion does not apply once the payments have been converted to any other type of resource.

(23) Cash payments an SSI recipient receives from a medical or social service agency to pay for medical or social services are excluded for one calendar month following the month of receipt.

(24) Payments from the Dutch government under the Netherlands' Act on Benefits for Victims of Persecution (WUV) are excluded. Interest earned on these payments is counted as unearned income as specified under chapter 388-450 WAC.

(25) Payments to survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act are excluded. Interest earned on these payments is counted as unearned income as specified under chapter 388-450 WAC.

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(26) Earned income tax credit refunds and payments are excluded as resources during the month of receipt and the following month.

(27) Payments from a state administered victim's compensation program are excluded for a period of nine calendar months after the month of receipt.

(28) Payments under section 500 through 506 of the Austrian General Social Insurance Act are not counted as a resource or income when a client's eligibility or post-eligibility (for institutionalized clients) is determined. A post-eligibility determination is the process of determining a client's share of the cost of institutional or waivered services care.

Any interest earned on the payments in this subsection is counted as unearned income as specified under WAC 388-450-0025.

(29) Payments from Susan Walker v. Bayer Corporation, et al., 96-c-5024 (N.D. Ill.) (May 8, 1997) settlement funds are excluded. Any interest earned on these payments is counted as unearned income as specified under WAC 388-450-0025.

(30) Cash received from the sale of an excluded resource is not counted when it is:

(a) Used to replace an excluded resource; or

(b) Invested in an excluded resource within the same month, unless specified differently under this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0040, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-511-1160.]

WAC 388-470-0045 Resources that are counted toward the resource limits for cash, food assistance and TANF-related medical programs. (1) The following resources are counted toward the resource limits for cash, food assistance and TANF-related medical programs:

(a) Liquid resources such as cash on hand, monies in checking or savings accounts;

(b) Motor home when not used as a residence; or

(d) Stocks or bonds minus any early withdrawal penalty.

(2) A resource owned with a person other than a spouse, contract vendor, mortgage or lien holder (jointly owned) is counted as follows:

(a) For cash assistance and TANF-related medical, the client's share of the equity value; or

(b) For food assistance, resources jointly owned by separate assistance units are considered available in their entirety to each assistance unit.

(3) A client may provide evidence that all or a portion of a jointly owned resource:

(a) Belongs to the other owner; and

(b) Is held for the benefit of the other owner.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0050 Resources that count. Unless otherwise specified the following resources count toward a cash or TANF-related medical assistance unit's resource limit:

(1) Burial insurance and term insurance: The cash surrender value in excess of fifteen hundred dollars.

(2) Child's irrevocable educational trust: Trust funds in excess of four thousand dollars per child.

(3) Life insurance: The cash surrender value of life insurance policies.

(4) Sales contracts, real estate mortgages, security interest: With the exception of sales contracts for the purposes of TANF-related medical, countable cash discount values.

(5) Savings accounts: For recipient's only, value in excess of three thousand dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0050, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0055 Resources that are counted for food assistance. The following resources are counted toward an assistance unit's resource limit:

(1) Excluded funds that are deposited in an account with countable funds (commingled) for more than six months from the date of deposit.

(2) Lump sums such as insurance settlements, refunded cleaning and damage deposits.

(3) Resources of ineligible household members, as described in WAC 388-408-0035(9).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0055, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0060 Resources of an alien's sponsor.

(1) Resources of a sponsor and the spouse who lives with the sponsor affects the eligibility of an alien for three years from the alien's date of entry into the U.S.

(2) A sponsor is any person or organization that signed an affidavit of support on behalf of the alien to allow the alien entry for permanent residence.

(3) The sponsor's countable resources are determined by:

(a) Totaling the countable resources of the sponsor and the sponsor's spouse (if they are living together); and

(b) Subtracting fifteen hundred dollars.

(4) Subsection (3) above does not apply when:

(a) The alien is receiving cash or food assistance as a member of the sponsor's assistance unit;

(b) An alien is sponsored by an organization; or

(c) An alien is not required to have a sponsor.

(5) The sponsor's countable resources are counted towards the alien's resource limit until:

(a) The three year time period expires; or

(b) The sponsor dies.

(6) For medical programs, the resources of the sponsor are excluded resources unless:

(a) The sponsor is a member of the alien's assistance unit; or

(b) The sponsor actually contributes resources to the alien's assistance unit.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0060, filed 7/31/98, effective 9/1/98. Formerly WAC 388-510-1030.]

WAC 388-470-0065 Individual development accounts for TANF recipients. (1) A TANF recipient's individual development account (IDA) established under RCW 74.08A.220 is excluded when determining TANF eligibility.

(2) When a TANF recipient withdraws funds from an IDA, for a purpose other than specified in RCW 74.08A.220,

the funds are a countable resource, as specified under WAC 388-470-0015(2).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0065, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0070 How vehicles are counted toward the resource limit for cash assistance and TANF/SFA-related medical. (1) A vehicle is any device for carrying persons and objects by land, water, or air.

(2) The entire value of a licensed vehicle needed to transport a physically disabled assistance unit member is excluded.

(3) The equity value of one vehicle up to five thousand dollars is excluded when the vehicle is used by the assistance unit or household as a means of transportation. Each separate medical assistance unit is allowed this exclusion.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-506-0610.]

WAC 388-470-0075 How vehicles are counted for food assistance. (1) The entire value of a licensed vehicle even during periods of temporary unemployment is excluded if the vehicle is:

(a) Used over fifty percent of the time for income-producing purposes. An excluded vehicle used by a self-employed farmer or fisher retains its exclusion for one year from the date the household member ends this self-employment.

(b) Used to produce income annually that is consistent with its fair market value (FMV).

(c) Necessary for long-distance travel that is essential to the employment of an assistance unit member whose resources are considered available to the assistance unit. Vehicles needed for daily commuting are not excluded under this provision.

(d) Necessary for hunting or fishing to support the household.

(e) Used as the assistance unit's home.

(f) Used to carry fuel for heating or water for home use when this is the primary source of fuel or water for the assistance unit.

(g) Needed to transport a temporarily or permanently physically disabled household member.

(2) The FMV in excess of four thousand six hundred fifty dollars is counted toward the assistance unit's resource limit for the following licensed vehicles if not excluded in subsection (1) above:

(a) One per assistance unit regardless of use;

(b) Used for transportation to and from work, training, or education; or

(c) Used for seeking employment.

(3) For all other licensed vehicles, the larger value of the following is counted toward the assistance unit's resource limit:

(a) FMV in excess of four thousand six hundred fifty dollars; or

(b) Equity value.

(4) Unlicensed vehicles driven by tribal members on the reservation are treated like a licensed vehicle.

(1999 Ed.)

(5) For unlicensed vehicles the equity value is counted towards the assistance unit's resource limit unless the vehicle is:

(a) Used to produce income annually that is consistent with its FMV even if used on a seasonal basis; or

(b) Work-related equipment necessary for employment or self-employment of an assistance unit member.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0075, filed 7/31/98, effective 9/1/98.]

WAC 388-470-0080 Compensatory award or related settlement lump sum payments. This section applies to cash and TANF-related medical assistance programs.

(1) A nonrecurring lump sum compensatory award or related settlement payment is excluded as a resource for the month payment was received.

(a) Compensatory awards are court awarded payments for wrongful death, personal injury, damage or loss of property.

(b) Related settlements are payments awarded without court intervention for wrongful death, personal injury, damage or loss of property.

(2) The portion of the compensatory award or related settlement payment received for repair or replacement of damaged or lost property or for medical bills is excluded as a resource for sixty days from the end of the month the payment was received.

(3) Any portion of the payment described under subsection (2) of this section is treated as an available resource when not used within sixty days from the month the payment was received.

(4) On the first of the month following receipt of the payment, the portion of the lump sum not excluded under subsection (1) of this section, is added to the client's existing resource value.

(a) If the client's total resource value is more than the resource limit, the client is not eligible for cash benefits beginning the first of the month following the month the payment was received.

(b) If the client's total resource value is less than the resource limit, the client is eligible for continued cash benefits, provided the client did not transfer the lump sum funds for less than adequate consideration as described in WAC 388-488-0005.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-470-0080, filed 7/31/98, effective 9/1/98.]

Chapter 388-472 WAC
RIGHTS AND RESPONSIBILITIES

WAC

388-472-0005 Rights and responsibilities.

WAC 388-472-0005 Rights and responsibilities. Unless specifically stated, the following rules apply to cash, food and medical assistance programs.

(1) A person who applies for or receives public assistance has the right to:

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(a) Be treated politely and fairly without regard to race, color, creed, political affiliation, national origin, religion, age, sex, disability, birthplace, or marital status;

(b) File an application on the same day, during regular business hours, that the person contacts the department. A client has the right to get a receipt when leaving an application or other materials with the department;

(c) Have an application promptly accepted and promptly acted upon;

(d) Ask that the application be processed without delay if the person is experiencing an emergency such as having no money for food, facing an eviction, needing medical care that cannot wait or being pregnant. If a pregnant client requests an interview, she has a right to have one within five working days;

(e) Get a written decision in most cases within thirty days. Medical and some disability cases may take forty-five to sixty days. Food stamps will be authorized within thirty days if the person is eligible. If the person is eligible and has little or no money, food stamps will be authorized within five days;

(f) Be fully informed, in writing, of all legal rights and responsibilities in connection with public assistance;

(g) Have information kept private. The department may share some facts with other agencies for efficient management of federal and state programs;

(h) For cash and medical assistance programs, ask the department not to collect child support if the absent parent may harm the person or person's child;

(i) For cash assistance programs, ask for extra money to help in an emergency, such as an eviction or a utility shutoff;

(j) Get a written notice, in most cases, at least ten days before the department makes changes to lower or stop benefits;

(k) Ask for a fair hearing if the person does not agree with the department about a decision. Without affecting the right to a fair hearing, the person can also ask a supervisor or administrator to review an employee decision or action;

(l) Have interpreter or translator services at no cost or undue delay;

(m) Refuse to speak to a fraud early detection (FRED) investigator from the division of fraud investigations. The person does not have to let an investigator into the home. The person may ask the investigator to come back at another time. Such a request will not affect the person's eligibility for benefits;

(n) For medical assistance programs only: A person applying for or receiving medical assistance, limited casualty programs, medical care services, or children's health services has the same rights as cash assistance clients; and

(o) Receive help from the department to register to vote.

(2) A client is responsible for:

(a) Reporting any changes to the department within ten days for all cash and food assistance programs and twenty days for all medical assistance programs;

(b) Giving all the facts needed to determine eligibility;

(c) Giving the department proof of any facts for which proof is needed;

(d) For most cash or medical assistance programs related to children, cooperating with the department to get child sup-

port or medical care support unless it can be shown that harm to the person or child may occur;

(e) For cash or medical assistance programs, applying for and taking any benefits from other programs, if eligible;

(f) Completing reports and reviews when asked to do so;

(g) Seeking and taking a job or training if required; and

(h) For medical assistance programs only, showing the medical identification card or other adequate department generated notification of eligibility to the medical care provider.

(3) Clients will be screened and provided with necessary supplemental accommodation as specified under WAC 388-200-1300.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.98-16-044, § 388-472-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0430, 388-504-0440, 388-504-0450 and 388-505-0560.]

Chapter 388-474 WAC

SUPPLEMENTAL SECURITY INCOME

WAC

388-474-0001	General information—Supplemental Security Income.
388-474-0005	Medical coverage.
388-474-0010	Eligibility for other programs.
388-474-0015	Termination of SSI.
388-474-0020	Duplicate assistance and overpayments.

WAC 388-474-0001 General information—Supplemental Security Income. (1) Persons with limited income and resources who are aged, blind, or disabled may qualify for federal cash benefits under the Supplemental Security Income program (SSI) administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

(2) The SSI program replaced state programs for aged, blind and disabled persons beginning in January, 1974. Persons who received state assistance in December, 1973, as aged, blind or disabled or were needed in the home to care for an eligible person, automatically became eligible for SSI in January, 1974.

(3) The spouse of an SSI recipient who does not qualify for SSI in their own right may be included in the state supplement payment but is not considered an SSI recipient for purposes of medical assistance eligibility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.98-16-044, § 388-474-0001, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0005 Medical coverage. (1) An SSI recipient qualifies for categorically needy (CN) medical coverage without a medical determination, except when the SSI recipient:

(a) Refuses to provide private medical insurance information or to assign the right to recover insurance funds to the department;

(b) Disposes of resources for less than fair market value and then applies for Medicaid coverage of nursing home care within thirty months of the date of transfer; or

(c) Has a Medicaid qualifying trust.

(2) A person designated as an essential person in January, 1974, qualifies for CN medical coverage as long as they continue to reside with the SSI recipient.

(3) The spouse of an SSI recipient designated as an ineligible spouse must have medical eligibility separately determined when:

(a) They do not automatically qualify for medical coverage in subsection (2) above; or

(b) They are not eligible for SSI in their own right.

(4) Persons who are not receiving SSI, but are SSI-related and qualify for CN medical assistance are described in WAC 388-505-0110.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0010 Eligibility for other programs.

(1) The spouse of an SSI recipient is not eligible for the state supplement for an ineligible spouse when they are authorized for TANF.

(2) The spouse of an eligible SSI recipient qualifies for inclusion in the SSI grant and is not eligible for general assistance benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0010, filed 7/31/98, effective 9/1/98.]

WAC 388-474-0015 Termination of SSI. (1) A person terminated from SSI cash assistance will have CN medical coverage continued when:

(a) Countable income exceeds the SSI income standard due solely to the annual cost-of-living adjustment (COLA); or

(b) A timely request for a hearing has been filed. Categorically needy medical coverage is continued until SSA makes a final decision on the hearing request and on any subsequent timely appeals.

(2) A person terminated from SSI is eligible for continued CN medical coverage for a period of up to one hundred twenty days from the date of termination of SSI cash benefits while eligibility for other cash or medical programs is being determined.

(3) A terminated SSI or SSI-related client will have their disability redetermined under certain conditions. These conditions are:

(a) The person presents new medical evidence;

(b) The person's medical condition changes significantly; or

(c) The termination from SSI was not based on a review of current medical evidence.

(4) Children terminated from SSI due to loss of status as a disabled person may be eligible for medical benefits under WAC 388-505-0210.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-524-2405.]

WAC 388-474-0020 Duplicate assistance and overpayments. (1) Persons receiving cash benefits under the general assistance program who receive advance, emergency or retroactive SSI cash assistance for the same time period are considered to have received duplicate assistance. The amount of general assistance paid during this time period must be repaid to the department.

(1999 Ed.)

(2) Applicants for general assistance-unemployable (GA-U) are required to sign DSHS 18-235(X), interim assistance reimbursement agreement (IARA) as a condition of eligibility for assistance.

(3) GA-U funds cannot be used to replace money deducted from a person's SSI check by SSA to repay an overpayment of SSI benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-474-0020, filed 7/31/98, effective 9/1/98.]

Chapter 388-476 WAC
SOCIAL SECURITY NUMBER

WAC

388-476-0005 Social Security Number requirements.

WAC 388-476-0005 Social Security Number requirements. (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security Number (SSN), or numbers if more than one has been issued.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;

(b) Provide proof that the SSN has been applied for; and

(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) A newborn may receive benefits for up to six months from the date of birth if the household is unable to provide proof of application for an SSN at the time of birth.

(5) For medical programs, a newborn as described in WAC 388-505-0210(1) is eligible for categorically needy (CN) medical without meeting the SSN requirement. These coverage provisions continue until one of the following occurs:

(a) The newborn leaves the household of the birth mother; or

(b) The newborn's first birthday.

(6) There is no SSN requirement for the following programs:

(a) The consolidated emergency assistance program;

(b) The refugee cash and medical assistance program;

(c) The medically indigent program;

(d) The alien emergency medical program;

(e) The state-funded pregnant woman program;

(f) The children's health program; and

(g) Detoxification services.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-476-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0530.]

[Title 388 WAC—p. 603]

Chapter 388-478 WAC
STANDARDS FOR PAYMENTS

WAC

388-478-0005	Cash assistance need and payment standards and grant maximum.
388-478-0010	Households with obligations to pay shelter costs.
388-478-0015	Cash assistance need standards.
388-478-0020	Payment standards for TANF, SFA, GA-S, GA-H and RCA.
388-478-0025	TANF payment standards for recent arrivals to Washington state.
388-478-0030	Payment standards for GA-U and ADATSA.
388-478-0035	Maximum earned income limits for TANF and SFA.
388-478-0040	Payment standard for persons in medical institutions.
388-478-0045	Payment standard for persons in certain group living facilities.
388-478-0050	Payment standards for recurring additional requirements.
388-478-0055	SSI standards.
388-478-0060	Income eligibility standards for food assistance.
388-478-0065	TANF/SFA-related categorically needy income level (CNIL) and resource standards.
388-478-0070	Monthly income and countable resource standards for medically needy and medically indigent (MN and MI) programs.
388-478-0075	Monthly income standards for federal poverty level income based programs.
388-478-0080	SSI-related CNIL medical monthly income and countable resource standards.
388-478-0085	Medicare cost sharing program monthly income and countable resources standards.

WAC 388-478-0005 Cash assistance need and payment standards and grant maximum. (1) Need standards for cash assistance programs represent the amount of income required by individuals and families to maintain a minimum and adequate standard of living. Need standards are based on assistance unit size and include basic requirements for food, clothing, shelter, energy costs, transportation, household maintenance and operations, personal maintenance, and necessary incidentals.

(2) Payment standards for assistance units in medical institutions and other facilities are based on the need for clothing, personal maintenance, and necessary incidentals (see WAC 388-478-0040 and 388-478-0045).

(3) Need and payment standards for persons and families who do not reside in medical institutions and other facilities are based on their obligation to pay for shelter.

WAC 388-478-0015 Cash assistance need standards. (1) The cash assistance need standards (and one hundred eighty-five percent of the need standards) for assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Need Standard	185%
1	\$ 795	\$1,471
2	1,005	1,860
3	1,244	2,302
4	1,463	2,707
5	1,686	3,119

(2) The cash assistance need standards (and one hundred eighty-five percent of the need standards) for assistance units with shelter provided at no cost are:

Assistance Unit Size	Need Standard	185%
1	\$ 478	\$ 884
2	605	1,119
3	749	1,386
4	880	1,628
5	1,014	1,876

(a) Eligibility and benefit levels for persons and families who meet the requirements in WAC 388-478-0010 are determined using standards for assistance units with an obligation to pay shelter costs.

(b) Eligibility and benefit levels for all other persons and families are determined using standards for assistance units who have shelter provided at no cost.

(c) For recent arrivals to Washington state who apply for temporary assistance for needy families (TANF), see WAC 388-478-0025.

(4) The monthly grant for an assistance unit containing eight or more persons cannot exceed the grant maximum of one thousand seventy-five dollars.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0010 Households with obligations to pay shelter costs. The monthly need and payment standards for cash assistance are based on a determination of assistance unit size and whether the assistance unit has an obligation to pay shelter costs.

Eligibility and benefit level is determined using standards for assistance unit with obligations to pay shelter costs if the assistance unit:

(1) Owns, purchases or rents its place of residence, even if costs are limited to property taxes, fire insurance, sewer, water, or garbage;

(2) Resides in a lower income housing project which is funded under the United States Housing Act of 1937 or Section 236 of the National Housing Act, if the household either pays rent or makes a utility payment in lieu of a rental payment; or

(3) Is homeless. Homeless households include persons or families who:

(a) Lack a fixed, regular, and adequate nighttime residence; or

(b) Reside in a public or privately operated shelter designed to provide temporary living accommodations; or

(c) Live in temporary lodging provided through a public or privately funded emergency shelter program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0010, filed 7/31/98, effective 9/1/98.]

Assistance Unit Size	Need Standard	185%
6	\$1,914	\$3,540
7	2,210	4,088
8	2,446	4,525
9	2,686	4,969
10 or more	2,919	5,400

Assistance Unit Size	Need Standard	185%
6	\$1,152	\$2,131
7	1,332	2,460
8	1,472	2,723
9	1,617	2,991
10 or more	1,757	3,250

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0015, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0020 Payment standards for TANF, SFA, GA-S, GA-H and RCA. (1) The payment standards for temporary assistance for needy families (TANF), state family assistance (SFA), general assistance for pregnant women (GA-S), general assistance for children (GA-H) and refugee cash assistance (RCA) assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	\$349	6	\$ 841
2	440	7	971
3	546	8	1,075
4	642	9	1,180
5	740	10 or more	1,283

(2) The payment standards for TANF, SFA, GA-S, GA-H and RCA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard	Assistance Unit Size	Payment Standard
1	\$212	6	\$ 511
2	268	7	591
3	332	8	654
4	391	9	718
5	451	10 or more	780

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710.]

WAC 388-478-0025 TANF payment standards for recent arrivals to Washington state. (1) Eligibility and benefit levels for temporary assistance for needy families (TANF) clients are determined according to length of residency and payment standard requirements established under RCW 74.08.025 (amended in section 101, chapter 58, Laws of 1997).

(2) The length of residency requirement does not apply to a dependent child who lives with a caretaker relative if the relative has resided in Washington for twelve or more consecutive months prior to applying for TANF benefits for the child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0025, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0030 Payment standards for GA-U and ADATSA. (1) The payment standards for general assistance - unemployable (GA-U) and alcohol and drug addiction treatment and support act (ADATSA) program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard
1	\$ 339
2	428

(2) The payment standards for GA-U and ADATSA assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	\$ 206
2	261

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0030, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0035 Maximum earned income limits for TANF and SFA. To be eligible for temporary assistance for needy families (TANF) or state family assistance (SFA), a family's gross earned income must be below the following levels:

Number of Family Members	Maximum Earned Income Level	Number of Family Members	Maximum Earned Income Level
1	\$ 698	6	\$1,682
2	880	7	1,942
3	1,092	8	2,150
4	1,284	9	2,360
5	1,480	10 or more	2,566

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0035, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0040 Payment standard for persons in medical institutions. (1) "Medical institutions" include skilled nursing homes, public nursing homes, general hospitals, tuberculosis hospitals, intermediate care facilities, and psychiatric hospitals approved by the joint commission on accreditation of hospitals (JCAH).

(2) The monthly payment standard for eligible persons in medical institutions is forty-one dollars and sixty-two cents. The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0040, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0045 Payment standard for persons in certain group living facilities. (1) A monthly grant payment of thirty-eight dollars and eighty-four cents will be made to eligible persons in the following facilities:

- (a) Congregate care facilities (CCF);
- (b) Adult residential rehabilitation centers/adult residential treatment facilities (AARC/ARTF); and
- (c) Division of developmental disabilities (DDD) group home facilities.

(2) The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0045, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0050 Payment standards for recurring additional requirements. Payment standards for recurring additional requirements approved under WAC 388-255-1050 through 388-255-1300:

- (1) Restaurant meals: \$187.09 per month (or \$6.04 per day with the payment rounded down to the nearest dollar amount);
- (2) Laundry: \$11.13 per month;
- (3) Guide dog or service animal food: \$33.66 per month;

(4) Home delivered meals: The amount charged by the agency providing the meals;

(5) Telephone: The minimum residential rate for the area; or the discounted amount established under the Washington telephone assistance program (WTAP), whichever is less;

(6) Winterizing homes: A maximum of \$500.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0050, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1110.]

WAC 388-478-0055 SSI standards. (1) Supplemental Security Income (SSI) is a cash assistance program for needy individuals and couples who meet federal disability guide-

lines as aged, blind or disabled. Since the SSI program began in January 1974, the state of Washington has supplemental the federal benefit level with state funds, known as the SSI state supplement. Persons found eligible for SSI receive cash assistance based on the combined federal and state supplement benefit levels, minus countable income.

(2) Effective January 1, 1998, the federal, state and combined benefit levels for an eligible individual and couple are:

(a) Area I: King, Pierce, Snohomish, Thurston, and Kitsap Counties.

(i) Living alone (own household or alternate care, except nursing homes or medical institutions).

	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
LIVING ALONE			
Individual	\$494.00	\$27.00	\$521.00
Individual with One Essential Person ¹	\$741.00	\$21.00	\$762.00
Couple, both Eligible	\$741.00	\$21.00	\$762.00
Couple with One Essential Person ²	\$741.00	\$21.00	\$762.00
Couple includes Ineligible Spouse	\$494.00	\$167.20	\$661.20

(ii) Shared living (supplied shelter).

	Federal Benefit Level	State Supplement Benefit Level	Combined Benefit Level
SHARED LIVING			
Individual	\$329.34	\$4.81	\$334.15
Individual with One Essential Person ³	\$494.00	\$5.30	\$499.30
Couple, Both Eligible	\$494.00	\$5.30	\$499.30
Couple includes One Essential Person ⁴	\$494.00	\$5.30	\$499.30
Couple includes Ineligible Spouse	\$329.34	\$102.76	\$432.10

(b) Area II: All counties other than the above.

(i) Living alone (own household or alternate care, except nursing homes or medical institutions).

	Federal Benefit Level	State Supplement Benefit Level	Combined Federal/State Benefit Level
LIVING ALONE			
Individual	\$494.00	\$6.55	\$500.55
Individual with One Essential Person ¹	\$741.00	\$0	\$741.00
Couple, Both Eligible	\$741.00	\$0	\$741.00
Couple with One Essential Person ²	\$741.00	\$0	\$741.00
Couple includes Ineligible Spouse	\$494.00	\$137.25	\$631.25

(ii) Shared living (supplied shelter).

	Federal Benefit Level	State Supplement Benefit Level	Combined Benefit Level
SHARED LIVING			
Individual	\$329.34	\$4.81	\$334.15
Individual with One Essential Person ³	\$494.00	\$5.30	\$499.30
Couple, Both Eligible	\$494.00	\$5.30	\$499.30
Couple includes One Essential Person ⁴	\$494.00	\$5.30	\$499.30
Couple includes Ineligible Spouse	\$329.34	\$102.76	\$432.10

(c) Residing in a medical institution: Area I and II

	Federal Benefit Level	State Supplement Benefit Level	Combined Benefit Level
MEDICAL INSTITUTION			
Individual	\$30.00	\$11.62	\$41.62

(d) Mandatory income level (MIL) for grandfathered claimant. "Grandfathered" refers to a person who qualified for assistance from the state as aged, blind, or disabled, was converted from the state to federal disability assistance under

SSI in January 1974, and has remained continuously eligible for SSI since that date.

The combined federal/state SSI benefit level for MIL clients is the higher of the following:

(i) The state assistance standard they received in December 1973, except for those converted in a "D" living arrangement (residing in a medical institution at the time of conversion), plus the federal cost-of-living adjustments (COLA) since then; or

(ii) The current standard.

¹ Eligible individual with more than one essential person living alone: \$494.00 for the eligible individual plus \$247.00 for each essential person (no state supplement).

² Eligible couple with one or more essential persons living alone: \$741.00 for eligible couple plus \$247.00 for each essential person (no state supplement).

³ Eligible individual with more than one essential person in shared living: \$329.34 for eligible individual plus \$164.66 for each essential person (no state supplement).

⁴ Eligible couple with one or more essential persons in shared living: \$494.00 for eligible couple plus \$164.66 for each essential person (no state supplement).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0055, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1115.]

WAC 388-478-0060 Income eligibility standards for food assistance. To be eligible for food assistance, assistance units must have income at or below both the maximum gross and net monthly income standards except as follows:

(1) Assistance units with an elderly or disabled member must have income at or below only the maximum net monthly income standard.

(2) Assistance units in which all members are receiving cash assistance or SSI do not have to meet the maximum gross or net monthly income standards.

EFFECTIVE 10-1-97				
Household Size	Maximum Gross Monthly Income	Maximum Net Monthly Income	165% of the Poverty Level	Maximum Allotment
1	\$ 855	\$ 658	\$1,085	\$122
2	1,150	885	1,459	224
3	1,445	1,111	1,833	321
4	1,739	1,338	2,207	408
5	2,034	1,565	2,581	485
6	2,329	1,791	2,955	582
7	2,623	2,018	3,329	643
8	2,918	2,245	3,703	735
9	3,213	2,472	4,077	827
10	3,508	2,699	4,451	919
Each Additional Member	+295	+227	+374	+92

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0060, filed 7/31/98, effective 9/1/98.]

WAC 388-478-0065 TANF/SFA-related categorically needy income level (CNIL) and resource standards. (1) The categorically needy income level (CNIL) standard for TANF-related medical is the same as the grant payment standards for the TANF cash program as stated in WAC 388-478-0020.

(2) The countable resource standards for TANF/SFA-related categorically needy (CN) medical are the same as those of the TANF/SFA cash program as stated in WAC 388-470-0005.

(3) For all medical programs an unborn child is counted as a household member when determining household size.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0065, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710 and 388-508-0820.]

WAC 388-478-0070 Monthly income and countable resource standards for medically needy and medically indigent (MN and MI) programs. (1) Beginning January 1, 1998, the medically needy income level (MNIL) and MI standards to be applied to a medical assistance unit are as follows:

(a) One person	\$521
(b) Two persons	\$592

(1999 Ed.)

(c) Three persons	\$667
(d) Four persons	\$742
(e) Five persons	\$858
(f) Six persons	\$975
(g) Seven persons	\$1,125
(h) Eight persons	\$1,242
(i) Nine persons	\$1,358
(j) Ten persons and more	\$1,483

(2) For persons meeting the institutional status requirements of chapter 388-513 WAC, a special MNIL is used. That standard is in WAC 388-513-1305(2).

(3) The MN and MI program countable resource standards are:

(a) One person	\$2,000
(b) A legally married couple	\$3,000
(c) For each additional family member add	\$50

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710, 388-507-0720, 388-511-1115, 388-518-1820, 388-518-1830, 388-518-1840 and 388-518-1850.]

WAC 388-478-0075 Monthly income standards for federal poverty level income based programs. (1) Income eligibility for the following medical programs is based upon the Federal Poverty Level (FPL) as established by the U.S. Department of Labor and updated annually:

[Title 388 WAC—p. 607]

- (a) Children's health program is one hundred percent of FPL,
- (b) Pregnant women's program is one hundred eighty-five percent of FPL, and
- (c) Children's categorically needy program is two hundred percent of FPL.
- (2) The FPL is effective as of April 1, 1998.

FAMILY

SIZE	100% FPL	185% FPL	200% FPL
1	\$ 671	\$1242	\$1342
2	\$ 905	\$1673	\$1809
3	\$1138	\$2105	\$2275
4	\$1371	\$2537	\$2742
5	\$1605	\$2968	\$3209
6	\$1838	\$3400	\$3675
7	\$2071	\$3832	\$4142
8	\$2305	\$4263	\$4609
9	\$2538	\$4695	\$5075
10	\$2771	\$5127	\$5542

Add to the ten person standard for each person over ten:

\$ 234	\$ 432	\$ 467
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- (3) There are no resource limits for the programs under this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0075, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0805, 388-508-0810, 388-509-0910, 388-509-0920, 388-509-0940 and 388-509-0960.]

WAC 388-478-0080 SSI-related CNIL medical monthly income and countable resource standards. (1) The SSI-related CNIL standard is the same as the SSI payment standard based upon the area of the state where the person lives. Area 1 is defined as the following counties: King, Pierce, Snohomish, Thurston and Kitsap. Area 2 is all other counties. The CNIL standards are as follows:

	Area 1	Area 2
(a) Single person	\$521.00	\$500.55
(b) A legally married couple both eligible	\$762.00	\$741.00

- (2) The resource standards for the SSI-related CN medical program are:

(a) One person	\$2,000
(b) A legally married couple	\$3,000

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0080, filed 7/31/98, effective 9/1/98. Formerly WAC 388-511-1110.]

WAC 388-478-0085 Medicare cost sharing program monthly income and countable resources standards. (1) The qualified Medicare beneficiary (QMB) program income standard is based upon one hundred percent of the Federal Poverty Level (FPL). Beginning April 1, 1998, this program's income standards are:

(a) One person	\$ 671
(b) Two persons	\$ 905

- (2) The special low-income Medicare beneficiary (SLMB) program income standard is over one hundred per-

cent of the FPL, but under one hundred twenty percent of the FPL. Beginning April 1, 1998, this program's income standards are:

	Minimum	Maximum
(a) One person	\$ 671.01	\$ 805
(b) Two persons	\$ 905.01	\$1085

(3) The expanded special low-income Medicare beneficiary (ESLMB) program income standard is over one hundred twenty percent of the FPL, but under one hundred thirty-five percent of the FPL. Beginning April 1, 1998, this program's income standards are:

	Minimum	Maximum
(a) One person	\$ 805.01	\$ 906
(b) Two persons	\$1085.01	\$1221

(4) The qualified disabled working individual (QDWI) program income standard is standard is based upon two hundred percent of the FPL. Beginning April 1, 1998, this program's income standards are:

(a) One person	\$1342
(b) Two persons	\$1809

(5) The qualified individual (QI) program income standard is over one hundred thirty-five percent of the FPL, but under one seventy-five percent of the FPL. Beginning April 1, 1998 this program's income standards are:

	Minimum	Maximum
(a) One person	\$ 906.01	\$1174
(b) Two persons	\$1221.01	\$1583

(6) The countable resource standards for all of the Medicare cost sharing programs in this sections are the same. These resource standards are:

(a) One person	\$4000
(b) Two persons	\$6000

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-478-0085, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1715, 388-517-1730, 388-517-1750 and 388-517-1770.]

Chapter 388-480 WAC STRIKERS

WAC
388-480-0001 Strikers.

WAC 388-480-0001 Strikers. (1) A strike is defined as a concerted work stoppage, slowdown or other interruption of work initiated by employees.

- (2) An individual is not considered a striker if:

- (a) Locked out by the employer;
- (b) Unable to work as a result of striking employees;
- (c) Not part of the bargaining unit on strike and fearful of personal injury from crossing picket lines;
- (d) Exempt from work registration the day before the strike (for reasons other than employment over thirty hours per week).

(3) TANF/SFA, GA-H or RCA recipients are not eligible for any month in which a parent or the only eligible child is participating in a strike on the last day of the month.

(4) In TANF/SFA, GA-H or RCA assistance units, if a member other than the parent or only eligible child is on strike on the last day of the month, only that person is ineligible.

(5) Applicants for food assistance are ineligible if participating in a strike unless:

(a) The household met all income and resource eligibility standards the day prior to the strike; and

(b) Is otherwise eligible at the time of application.

(6) Food assistance households are not eligible for an increase in benefits solely due to a decrease in income as a direct result of participation in a strike.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-480-0001, filed 7/31/98, effective 9/1/98.]

Chapter 388-482 WAC STUDENT STATUS

WAC

388-482-0005 Student status for food assistance.

WAC 388-482-0005 Student status for food assistance. (1) A food assistance client is considered a student when the client is:

(a) Aged eighteen through forty-nine years;

(b) Physically and mentally able to work; and

(c) Enrolled at least half time in an institution of higher education as defined by the institution.

(2) An institution of higher education is:

(a) Any educational institution requiring a high school diploma or general education development certificate (GED);

(b) Business, trade or vocational schools requiring a high school diploma or GED; or

(c) A two-year or four-year college or university offering a degree but not requiring a high school diploma or GED.

(3) To be an eligible student in the food assistance programs, a student as defined in subsection (1) of this section must meet one of the following:

(a) Work and receive pay for a average of twenty hours each week. A self-employed student's weekly earnings must be equal to or above the federal minimum wage multiplied by twenty hours.

(b) Work and receive money from a federal or state work study program;

(c) Be responsible for the care of their child age five or younger;

(d) Be responsible for the care of their child six through eleven years of age and the department has determined that there is not adequate child care available during the school year to allow the student to:

(i) Attend class and satisfy the twenty hour work requirement; or

(ii) Take part in a work study program.

(e) Be a single parent responsible for the care of their child eleven years old or younger even if child care is available;

(f) Be an adult who has parental control of a child eleven years of age or younger and neither the adult's spouse nor the child's parents reside in the home;

(1999 Ed.)

(g) Participate in the WorkFirst program as required under WAC 388-310-400;

(h) Receive benefits from TANF or SFA;

(i) Attend an institution of higher education through:

(i) The job training partnership act (JTPA);

(ii) Food assistance employment and training program (FS E&T);

(iii) An approved state or local employment and training program; or

(iv) Section 236 of the Trade Act of 1974.

(4) Student status:

(a) Begins the first day of the school term; and

(b) Continues through vacations. Vacations include the summer when the student plans to return to school for the next term.

(5) If the only reason a student is eligible for food assistance is the participation in work study, the student becomes ineligible during the summer months if the student is not working and receiving money from work study. Consider other student eligibility criteria during the summer months.

(6) Student status ends when a student:

(a) Graduates;

(b) Is suspended or expelled;

(c) Drops out; or

(d) Does not intend to register for the next school term other than summer.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-482-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-484 WAC TANF/SFA FIVE YEAR TIME LIMIT

WAC

388-484-0005 Five year time limit for TANF and SFA.

WAC 388-484-0005 Five year time limit for TANF and SFA. (1) A family is not eligible for TANF or SFA if the family includes an adult who has received TANF or SFA for sixty months after August 1, 1997.

(2) In calculating the number of months an adult family member has received TANF or SFA, a month is not counted if the adult received assistance:

(a) As a minor child who was not the head of a household or married to the head of a household. A minor child is not the head of a household when residing with a parent, legal guardian, or other adult relative, or living in a department-approved living arrangement under the supervision of a non-related adult; or

(b) When living in Indian country, as defined under 18 U.S.C. 1151, or an Alaskan Native village, if during the months the individual received TANF or SFA at least fifty percent of the adults living on the reservation or in the village were unemployed.

(3) An adult who has received fifty-two months of TANF or SFA may be exempted from the five-year time limit for reasons of hardship or family violence if the total number of exempted cases does not exceed twenty percent of the average monthly number of TANF and SFA cases statewide during a fiscal year.

[Title 388 WAC—p. 609]

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-484-0005, filed 7/31/98, effective 9/1/98.]

Chapter 388-486 WAC TEEN PARENTS

WAC

388-486-0005	Unmarried pregnant or parenting minors—Required living arrangement.
388-486-0010	Unmarried pregnant or parenting minors—Required school attendance.

WAC 388-486-0005 Unmarried pregnant or parenting minors—Required living arrangement. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) The following definitions apply to terms used in this section:

(a) "Unmarried" means a person who have never been married or whose marriage has been annulled. It does not include a person who has been divorced or widowed.

(b) "Minor" means a person younger than eighteen years of age.

(c) "Legal guardian" means a court-appointed legal guardian or court-appointed permanent custodian.

(d) "Relative" is a person who related to the pregnant or parenting minor as defined under RCW 74.15.020(4).

(3) An unmarried pregnant or parenting minor is not eligible for TANF, SFA or GA-S unless the person:

(a) Has been emancipated by a court; or

(b) Lives in a home approved by the department and has a protective payee.

(4) The home of a minor's parent, legal guardian, or adult relative may be approved unless:

(a) The minor has no living parent, legal guardian, or adult relative that can be located or those persons do not want the minor to live with them;

(b) The minor or the minor's child is being or has been seriously harmed either physically, emotionally or sexually in the home of the parent, legal guardian, or adult relative;

(c) Substantial evidence exists of an act or failure to act by the parent, legal guardian, or adult relative that presents imminent or serious harm to the minor or the minor's child if they lived there; or

(d) The department determines that it is in the best interest of the minor or the minor's child to waive the requirement of living in the home of a parent, legal guardian, or adult relative.

(5) If the home of a minor's parent, legal guardian, or adult relative is not available or suitable, one of the following alternatives may be approved:

(a) A facility or home licensed under chapter 74.15 RCW that provides a supportive and supervised living arrangement requiring residents to learn parenting skills;

(b) A maternity home;

(c) Other adult-supervised living arrangement; or

(d) The minor's current or proposed living arrangement, if the department determines it is appropriate.

(6) A home that includes the other natural parent of the minor's child or unborn child is never approved if:

(a) The minor is under age sixteen; and

(b) The other parent is eighteen or older and meets the age criteria for rape of a child as set forth in RCW 9A.44.073, 9A.44.076, and 9A.44.079.

(7) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-486-0005, filed 7/31/98, effective 9/1/98.]

WAC 388-486-0010 Unmarried pregnant or parenting minors—Required school attendance. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) To be eligible for TANF or SFA, an unmarried pregnant or parenting minor who has not completed high school or a general education development (GED) certificate program must participate in educational activities leading to the attainment of a high school diploma or GED.

(3) The minor must meet the standard for satisfactory attendance set by the school or program in which the minor is enrolled.

(4) An unmarried minor is exempt from this rule if the minor has:

(a) Been emancipated by a court; or

(b) A child who is less than twelve weeks old.

(5) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-486-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-488 WAC TRANSFER OF PROPERTY

WAC

388-488-0005	Transfer of property to qualify for cash assistance.
388-488-0010	Transfer of property to qualify for food assistance.

WAC 388-488-0005 Transfer of property to qualify for cash assistance. This rule applies to cash assistance programs only and does not affect Medicaid eligibility for a person who is not institutionalized. For transfer of property for institutional medical see WAC 388-513-1365.

(1) An assistance unit is disqualified from receiving benefits when it transferred or transfers real or personal property for less than its market value in an attempt to qualify for benefits:

(a) Two years prior to the date of application;

(b) During the application process; or

(c) Anytime while receiving benefits.

(2) When an assistance unit transferred property for less than its fair market value in an attempt to qualify for benefits, the disqualification period:

(a) For applicants, begins the first day of the month the property was transferred.

(b) For recipients, begins the first day of the month after the month the property was transferred.

(3) To determine the number of months an assistance unit will be disqualified, divide the uncompensated resource value of the transferred property by the state gross median income. The uncompensated resource value is the equity value minus the amount the client received when transferring a resource.

(4) An assistance unit can provide evidence to clarify the reasons for transferring the property when the department presumes that the assistance unit transferred the property in an attempt to qualify for benefits.

(5) The benefits received by an assistance unit are not affected by the transfer of separate property of a spouse who is not a member of the assistance unit.

(6) An assistance unit's disqualification period is reduced when the client:

(a) Verifies undue hardship will exist if the benefits are denied such as an eviction;

(b) Secures a return of some or all of the transferred property or the equivalent value of the transferred property;

(c) Verifies an unforeseen change in circumstances such as extensive hospitalization; or

(d) Is responsible for and can verify medical expenses.

(7) When a disqualification period has been adjusted and the client is otherwise eligible, benefits will be authorized. Any benefits authorized because of the reason(s) in subsection (6) of this section, are not considered an overpayment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-488-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580 and 388-518-1820.]

WAC 388-488-0010 Transfer of property to qualify for food assistance. (1) An assistance unit is disqualified from the program when it transfers a resource to qualify or attempt to qualify for benefits:

(a) Three months prior to the month of application; or

(b) Beginning the month the household is approved for benefits.

(2) The length of disqualification depends on the dollar amount the household is over the resource limit. The countable resources transferred are added to the assistance unit's other countable resources. This total is compared to the resource limit. The amount in excess of the resource limit is located on the chart below to determine the length of the disqualification period.

Amount Over the Resource Limit	Disqualification Period
\$ 0 - \$ 249.99	1 month
250 - 999.99	3 months
1,000 - 2,999.99	6 months
3,000 - 4,999.99	9 months
5,000 and over	12 months

(3) The disqualification period begins:

(a) For applicants, the month of application; or

(b) For recipients, the first of the month after the advance notice period expires.

(4) An assistance unit will not be disqualified for transferring the following:

(1999 Ed.)

(a) Excluded resources that do not affect eligibility;

(b) Resources sold or traded at or near fair market value (FMV);

(c) Resources transferred between assistance unit members of the same household including ineligible household members; and

(d) Resources transferred for reasons other than to qualify for benefits.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-488-0010, filed 7/31/98, effective 9/1/98.]

Chapter 388-490 WAC

VERIFICATION

WAC

388-490-0005 Documents or information needed to determine eligibility.

WAC 388-490-0005 Documents or information needed to determine eligibility. The department requires clients to provide documents or information to establish the accuracy of a client's circumstances or statements. This is called mandatory verification and varies by program. The following requirements are for cash, food assistance and medical unless otherwise specified.

(1) A client has primary responsibility for providing information and verification.

(2) Time frames and notice requirements for requested information are stated in:

(a) WAC 388-406-0030 and 388-406-0035 for applicants; and

(b) WAC 388-418-0010 for recipients.

(3) The department requests verification from clients when it is needed to determine eligibility.

(4) The department accepts readily available verification that reasonably supports the client's statement or circumstances. Readily available means verification that can be obtained by the client within three working days.

(5) A client's signature on the application, eligibility review, or change of circumstance form gives the department consent to obtain supporting evidence from the following sources:

(a) A collateral contact. A collateral contact is an oral or written statement from someone outside of the assistance unit that confirms a client's circumstances; or

(b) A home visit.

(6) When a client is required to provide a document that requires a fee, the department will pay the fee.

(7) A client's benefits are not denied, terminated or delayed because of a failure to provide a specific type or form of verification.

(8) If all requested verification is not received, a client's eligibility is determined based on all available evidence.

(9) If eligibility cannot be determined from the available evidence that was provided, the client's benefits are denied or terminated.

(10) When verification was previously provided before and the document is not subject to change, a client is not required to provide the verification again. This applies when the department determines eligibility at:

[Title 388 WAC—p. 611]

- (a) The next application;
- (b) Reinstatement of a program; or
- (c) Redetermination of eligibility.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.98-16-044, § 388-490-0005, filed 7/31/98, effective 9/1/98. Formerly WAC 388-504-0460.]

Chapter 388-500 WAC MEDICAL DEFINITIONS

WAC

388-500-0005 Medical definitions.

WAC 388-500-0005 Medical definitions. Unless defined in this chapter or in other chapters of the *Washington Administrative Code*, use definitions found in the *Webster's New World Dictionary*. This section contains definitions of words and phrases the department uses in rules for medical programs. Definitions of words used for both medical and financial programs are defined under WAC 388-22-030.

"Assignment of rights" means the client gives the state the right to payment and support for medical care from a third party.

"Base period" means the time period used in the limited casualty program which corresponds with the months considered for eligibility.

"Beneficiary" means an eligible person who receives:

*A federal cash Title XVI benefit; and/or

*State supplement under Title XVI; or

*Benefits under Title XVIII of the Social Security Act.

"Benefit period" means the time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a "spell of illness" for Medicare payments.

"Cabulance" means a vehicle for hire designed and used to transport a physically restricted person.

"Carrier" means:

*An organization contracting with the federal government to process claims under Part B of Medicare; or

*A health insurance plan contracting with the department.

"Categorical assistance unit (CAU)" means one or more family members whose eligibility for medical care is determined separately or together based on categorical relatedness.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-503-0310, chapter 388-517 WAC and WAC 388-523-2305.

"Children's health program" means a state-funded medical program for children under age eighteen:

*Whose family income does not exceed one hundred percent of the federal poverty level; and

[Title 388 WAC—p. 612]

*Who are not otherwise eligible under Title XIX of the Social Security Act.

"Coinsurance-Medicare" means the portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is twenty percent of reasonable charges.

"Community services office (CSO)" means an office of the department which administers social and health services at the community level.

"Couple" means, for the purposes of an SSI-related client, an SSI-related client living with a person of the opposite sex and both presenting themselves to the community as husband and wife. The department shall consider the income and resources of such couple as if the couple were married except when determining institutional eligibility.

"Deductible-Medicare" means an initial specified amount that is the responsibility of the client.

"Part A of Medicare-inpatient hospital deductible" means an initial amount of the medical care cost in each benefit period which Medicare does not pay.

"Part B of Medicare-physician deductible" means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay.

"Delayed certification" means department approval of a person's eligibility for medicaid made after the established application processing time limits.

"Department" means the state department of social and health services.

"Early and periodic screening, diagnosis and treatment (EPSDT)" also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid or the children's health program.

"Electronic fund transfers (EFT)" means automatic bank deposits to a client's or provider's account.

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

*Placing the patient's health in serious jeopardy;

*Serious impairment to bodily functions; or

*Serious dysfunction of any bodily organ or part.

"Emergency medical expense requirement" means a specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program.

"Essential spouse" see "spouse."

"Extended care patient" means a recently hospitalized Medicare patient needing relatively short-term skilled nursing and rehabilitative care in a skilled nursing facility.

"Garnishment" means withholding an amount from earned or unearned income to satisfy a debt or legal obligation.

"Grandfathered client" means:

(1999 Ed.)

*A noninstitutionalized person who meets all current requirements for Medicaid eligibility except the criteria for blindness or disability; and

*Was eligible for Medicaid in December 1973 as blind or disabled whether or not the person was receiving cash assistance in December 1973; and

*Continues to meet the criteria for blindness or disability and other conditions of eligibility used under the Medicaid plan in December 1973; and

*An institutionalized person who was eligible for Medicaid in December 1973 or any part of that month, as an inpatient of a medical institution or resident of an intermediate care facility that was participating in the Medicaid program and for each consecutive month after December 1973 who:

*Continues to meet the requirements for Medicaid eligibility that were in effect under the state's plan in December 1973 for institutionalized persons; and

*Remains institutionalized.

"Health maintenance organization (HMO)" means an entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis.

"Healthy kids," see "EPSDT."

"Home health agency" means an agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

"Hospital" means an institution licensed as a hospital by the department of health.

"Income for an SSI-related client," means the receipt by an individual of any property or service which the client can apply either directly, by sale, or conversion to meet the client's basic needs for food, clothing, and shelter.

"Earned income" means gross wages for services rendered and/or net earnings from self-employment.

"Unearned income" means all other income.

"Institution" means an establishment which furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. This includes medical facilities, nursing facilities, and institutions for the mentally retarded.

"Institution-public" means an institution, including a correctional institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

"Institution for mental diseases" means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services.

"Institution for the mentally retarded or a person with related conditions" means an institution that:

*Is primarily for the diagnosis, treatment or rehabilitation of the mentally retarded or a person with related conditions; and

*Provides, in a protected residential setting, on-going care, twenty-four hour supervision, evaluation, and planning to help each person function at the greatest ability.

"Institution for tuberculosis" means an institution for the diagnosis, treatment, and care of a person with tuberculosis.

"Medical institution" means an institution:

*Organized to provide medical care, including nursing and convalescent care;

*With the necessary professional personnel, equipment and facilities to manage the health needs of the patient on a continuing basis in accordance with acceptable standards;

*Authorized under state law to provide medical care; and

*Staffed by professional personnel. Services include adequate physician and nursing care.

"Intermediary" means an organization having an agreement with the federal government to process Medicare claims under Part A.

"Legal dependent" means a person for whom another person is required by law to provide support.

"Limited casualty program (LCP)" means a medical care program for medically needy, as defined under WAC 388-503-0320 and for medically indigent, as defined under WAC 388-503-0370.

"Medicaid" means the federal aid Title XIX program under which medical care is provided to persons eligible for:

*Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or

*Medically needy program as defined in WAC 388-503-0320;

"Medical assistance." See **"Medicaid."**

"Medical assistance administration (MAA)" means the unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs.

"Medical assistance unit (MAU)" means one or more family members whose eligibility for medical care is determined separately or together based on financial responsibility.

"Medical care services" means the limited scope of care financed by state funds and provided to general assistance (GAU) and ADATSA clients.

"Medical consultant" means a physician employed by the department.

"Medical facility" see **"Institution."**

"Medically indigent (MI)" means a state-funded medical program for a person who has an emergency medical condition requiring hospital-based services.

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Medically needy (MN)" is the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income

above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

"Medicare" means the federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

***"Part A"** covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

***"Part B"** is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

"Medicare assignment" means the method by which the provider receives payment for services under Part B of Medicare.

"Month of application" means the calendar month a person files the application for medical care. When the application is for the medically needy program, at the person's request and if the application is filed in the last ten days of that month, the month of application may be the following month.

"Nursing facility" means any institution or facility the department [of health] licenses as a nursing facility, or a nursing facility unit of a licensed hospital, that the:

*Department certifies; and

*Facility and the department agree the facility may provide skilled nursing facility care.

"Outpatient" means a nonhospitalized patient receiving care in a hospital outpatient or hospital emergency department, or away from a hospital such as in a physician's office, the patient's own home, or a nursing facility.

"Patient transportation" means client transportation to and from covered medical services under the federal Medicaid and state medical care programs.

"Physician" means a doctor of medicine, osteopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed.

"Professional activity study (PAS)" means a compilation of inpatient hospital data, conducted by the commission of professional and hospital activities, to determine the average length of hospital stay for patients.

"Professional review organization for Washington (PRO-W)" means the state level organization responsible for determining whether health care activities:

*Are medically necessary;

*Meet professionally acceptable standards of health care; and

*Are appropriately provided in an outpatient or institutional setting for beneficiaries of Medicare and clients of Medicaid and maternal and child health.

"Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law to:

*Artificially replace a missing portion of the body;

*Prevent or correct physical deformity or malfunction; or

*Support a weak or deformed portion of the body.

"Provider" or **"provider of service"** means an institution, agency, or person:

*Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and

*Is eligible to receive payment from the department.

"Resources for an SSI-related client," means cash or other liquid assets or any real or personal property that an individual or spouse, if any, owns and could convert to cash to be used for support or maintenance.

*If an individual can reduce a liquid asset to cash, it is a resource.

*If an individual cannot reduce an asset to cash, it is not considered an available resource.

*Liquid means properties that are in cash or are financial instruments which are convertible to cash such as, but not limited to, cash, savings, checking accounts, stocks, mutual fund shares, mortgage, or a promissory note.

*Nonliquid means all other property both real and personal evaluated at the price the item can reasonably be expected to sell for on the open market.

"Retroactive period" means the three calendar months before the month of application.

"Spell of illness" see **"benefit period."**

"Spenddown" means the process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department.

"Spouse" means:

***"Community spouse"** means a person living in the community and married to an institutionalized person or to a person receiving services from a home and community-based waivered program as described under chapter 388-515 WAC.

***"Eligible spouse"** means an aged, blind or disabled husband or wife of an SSI-eligible person, with whom such a person lives.

***"Essential spouse"** means, a husband or wife whose needs were taken into account in determining old age assistance (OAA), aid to the blind (AB), or disability assistance (DA) client for December 1973, who continues to live in the home and to be the spouse of such client.

***"Ineligible spouse"** means the husband or wife of an SSI-eligible person, who lives with the SSI-eligible person and who has not applied or is not eligible to receive SSI.

***"Institutionalized spouse"** means a married person in an institution or receiving services from a home or community-based waivered program.

***"Nonapplying spouse"** means an SSI-eligible person's husband or wife, who has not applied for assistance.

"SSI-related" means an aged, blind or disabled person not receiving an SSI cash grant.

"Supplemental security income (SSI) program, Title XVI" means the federal grant program for aged, blind, and disabled established by section 301 of the Social Security amendments of 1972, and subsequent amendments, and administered by the Social Security Administration (SSA).

"Supplementary payment (SSP)" means the state money payment to persons receiving benefits under Title XVI, or who would, but for the person's income, be eligible for such benefits, as assistance based on need in supplementation of SSI benefits. This payment includes:

"Mandatory state supplement" means the state money payment to a person who, for December 1973, was a client receiving cash assistance under the department's former programs of old age assistance, aid to the blind and disability assistance; and

"Optional state supplement" means the elective state money payment to a person eligible for SSI benefits or who, except for the level of the person's income, would be eligible for SSI benefits.

"Third party" means any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

"Title XIX" is the portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

"Transfer" means any act or omission to act when title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person; including delivery of personal property, bills of sale, deeds, mortgages, pledges, or any other instrument conveying or relinquishing an interest in property. Transfer of title to a resource occurs by:

*An intentional act or transfer; or

*Failure to act to preserve title to the resource.

"Value-fair market for an SSI-related person" means the current value of a resource at the price for which the resource can reasonably be expected to sell on the open market.

"Value of compensation received" means, for SSI-related medical eligibility, the gross amount paid or agreed to be paid by the purchaser of a resource.

"Value-uncompensated" means, for SSI-related medical eligibility, the fair market value of a resource, minus the amount of compensation received in exchange for the resource.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-500-0005, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090, 95-22-039 (Order 3913, #100246), § 388-500-0005, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-500-0005, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-80-005, 388-82-006, 388-92-005 and 388-93-005.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

388-501-0165 Medical services request.
388-501-0175 Medical care provided in bordering cities.
388-501-0180 Out-of-state medical care.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-501-0105 Applicability. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0105, filed 5/3/94, effective 6/3/94. Formerly WAC 388-80-002.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

388-501-0110 Purpose of the medical care program. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0110, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-81-005, 388-81-025, 388-99-005 and 388-100-005.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.

388-501-0140 Fraud. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0140, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-446-0001.

388-501-0170 Third party resources. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0170, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-010 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0540.

388-501-0190 Maternity care distressed area. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0190, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-070.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.

WAC 388-501-0125 Requirements for advance directives. (1) Each hospital, nursing facility, provider of home health care or personal care services, hospice program, or health maintenance organization receiving Medicaid funds shall as providers under this section:

(a) Maintain written policies and procedures concerning a person's right to make medical decisions including advance directives;

(b) Provide written information to all adults as defined in RCW 26.28.010 and 26.28.015 receiving medical care by or through the provider or organization to include the person's right to:

- (i) Make decisions concerning the person's medical care;
- (ii) Accept or refuse surgical or medical treatment; and
- (iii) Formulate advance directives.

(c) Provide written information to all adults on policies concerning implementation of these rights;

(d) Document in the person's medical record whether or not the person has executed an advance directive;

(e) Not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive;

(f) Ensure compliance with the requirements of chapters 11.94, 68.50, and 70.122 RCW concerning advance directives.

(g) Provide for educating staff and the community on the requirements for advance directives.

(2) For the purpose of this section, the term "advance directive" means a voluntarily written instruction, such as a

Chapter 388-501 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—GENERAL

WAC

388-501-0125 Requirements for advance directives.
388-501-0130 Administrative controls.
388-501-0135 Patient requiring regulation.
388-501-0150 Confidential records.
388-501-0160 Exception to policy.

living will, durable power of attorney for health care, or anatomical gift recognized under state law (whether statutory or as recognized by the courts of the state) and relating to the provision of such care when the person is incapacitated.

(3) The written material distributed by the providers as defined concerning medical decision making shall summarize state law found in statute and case law and may include the actual law, copies of the statute, case law, or forms.

(4) The provider as defined shall give information concerning these rights to adults as follows:

(a) Hospitals at the time of the person's admission as an inpatient;

(b) Nursing facility at the time of the person's admission as a resident;

(c) Provider of home health care or personal care services before the person comes under the care of the provider;

(d) Hospice program at the time of the initial receipt of hospice care by the person in the program; and

(e) Health maintenance organization at the time of enrollment of the person with the organization.

(5) This section shall not be construed to require any physician to implement an advance directive, when the physician objects on the basis of conscience. When the physician refuses to implement the directive, the physician shall make a good faith effort to transfer the person to another physician who will implement the person's directive.

(6) When a person in a comatose or otherwise incapacitated state, unable to receive information or to say whether an advance directive has been executed, comes under the care of a provider, the provider shall include information concerning advance directives with materials about the provider's policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated person as specified under RCW 7.70.065. The provider shall be obligated to provide this information to the person once the person is no longer incapacitated.

(7) When a person is incapacitated or otherwise unable to receive information or articulate whether such person has executed an advance directive and no one comes forward with a previously executed advance directive, the provider shall document in a person's file that the person was unable to receive information and was unable to communicate whether an advance directive exists.

(8) When the patient or a relative, surrogate, or other interested person presents the provider with a copy of the person's advance directive, the provider shall comply, except as specified under subsection (5) of this section, with the advance directive.

[Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-501-0125, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-017.]

WAC 388-501-0130 Administrative controls. The department shall establish and enforce such administrative controls as may be necessary to prevent abuses by vendors or clients including, but not limited to, determination of need for and duration of services, assurance of justification of services, reasonableness of costs, and operation of the program within limits of the legislative appropriation.

(1) The department shall conduct audits and investigations of providers of medical and other services provided as

authorized by chapter 74.09 RCW to determine compliance with the rules and regulations of the program.

(a) In the conduct of such audits or investigations, the secretary or authorized representative may examine only those records or portion thereof, including patient records, pertaining to services rendered by a health care provider and reimbursed by the department. Copies of, but not original, records shall be removed from the premises of the health care provider. The secretary shall destroy all copies of client medical records made during an audit or investigation. This destruction will take place not later than ninety days after the date when no further actions, concerning a particular audit, can be taken or are going to be taken by the department, the provider, or the courts. The department shall notify the provider in writing that such destruction has taken place.

(b) The department shall give twenty days advance notice to a provider that the patient medical records are to be audited for compliance with program rules and standards. This notice shall not:

(i) Apply to provider investigations for fraudulent or abusive practices;

(ii) Include names of patient files to be reviewed. For the purposes of this section, prescriptions or records of drugs dispensed are not to be defined as patient medical records; and

(iii) Apply to Medicaid provider business and financial records and patient financial records when reviewed as part of a third-party liability compliance audit.

(c) The department shall work with the provider to minimize inconvenience and disruption of health care delivery.

(2) In conducting a probability sample audit, the department shall select the sample on the basis of recognized and generally accepted sampling methods. The department shall examine the sample for compliance with relevant federal and state laws and regulations, department billing instructions and department numbered memoranda. The department shall use a sample that is sufficient to ensure a minimum ninety-five percent confidence level when projecting the overpayment.

(a) The department shall recover statistically calculated overpayments made to Washington state Title XIX providers when the department utilizes probability sampling and the audit findings demonstrate an overpayment has been made. The department shall ensure all overpayments and underpayments reflected in the probability sample are totaled and extrapolated to the universe from which the sample was drawn to calculate the amount to be recovered. The department shall not consider nonbilled services or supplies in the calculation of underpayments and overpayments.

(b) When the results of a probability sample are used to extrapolate the amount to be recovered, the department shall ensure the demand for recovery is accompanied by a clear description of:

(i) The universe from which the sample was drawn;

(ii) The sample size and method used to select the sample; and

(iii) The formulas and calculation procedures used to determine the amount to be recovered.

(c) As used in this section, the department shall apply the following definitions:

(i) "Extrapolation" means the methodology whereby an unknown value can be estimated by projecting the results of a probability sample to the universe from which the sample was drawn with a calculated precision (margin of error); and

(ii) "Probability sampling" means the standard statistical methodology in which a sample is selected based on the theory of probability (a mathematical theory used to study the occurrence of random events).

(3) Based upon the findings of an audit, investigation, or other proceeding, the secretary or authorized representative may order repayment of excess benefits or payments received by the provider, plus interest on the amount of excess benefits and assess civil penalties as provided for in chapter 74.09 RCW. The department shall assess civil penalties in an amount not to exceed three times the amount of excess benefits or payments received by the provider.

(4) When the department imposes a civil penalty or suspends or terminates a provider from the program, the department shall give written notice of the action taken to the appropriate licensing agency and/or disciplinary board. The department may refer to the appropriate disciplinary board providers who have demonstrated a significant noncompliance with the provisions of the medical care program through the results of an audit, investigation, or utilization review function. The Washington state medical disciplinary board shall generally serve in an advisory capacity to the secretary in the conduct of audits or investigations of physicians.

(5) The secretary or authorized representative shall refer all cases to the appropriate prosecuting authority for possible criminal action where the department finds substantial evidence supporting a finding of fraud. *Prima facie* evidence does not, in itself, provide a substantial basis for criminal prosecution.

[Statutory Authority: RCW 74.08.090 and 74.09.290. 96-06-041 (Order 3949), § 388-501-0130, filed 3/1/96, effective 4/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0130, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-015.]

WAC 388-501-0135 Patient requiring regulation. (1)

Patient requiring regulation (PRR) is a health and safety program for clients needing help in the appropriate use of medical services. A client in PRR is restricted to one primary care provider (PCP) and one pharmacy. Enrollment in the PRR program is for twenty-four months.

(2) Any client of the department's medical programs is reviewed for assignment to PRR if:

(a) The client has:

(i) Made repeated and documented efforts to seek medically unnecessary health services; and

(ii) Been counseled at least once by a health care provider or managed care plan representative about the appropriate use of health care services; or

(b) Any three of the following conditions have been met or exceeded in a ninety-day period. The client:

(a) Received services from four different physicians; or

(b) Had prescriptions filled by four different pharmacies; or

(c) Received ten prescriptions; or

(d) Had prescriptions filled by four different prescribers; or

(1999 Ed.)

(e) Used two emergency room (ER) visits.

(3) If subsections (2)(a) or (b) of this section apply, then the client's use of medical services is reviewed by the department. The review considers the client's diagnoses, history of services provided, or other medical information supplied by the health care provider or managed care plan. The review is done by a nurse consultant, physician, or other qualified medical staff according to established medical review guidelines.

(4) If the medical review finds that the client uses inappropriate or medically unnecessary services the client receives written notice which:

(a) Asks the client to select a primary care provider and one pharmacy; and

(b) Notifies the client of their right to request a fair hearing within ninety days (see subsection (6) of this section); and

(c) Requires the client to respond within twenty days by:

(i) Selecting a primary care provider and pharmacy; or

(ii) Submitting additional medical information, which justifies the client's use of medical services; or

(iii) Writing or calling the PRR representative, who is identified in the PRR notice, requesting assistance; or

(iv) Requesting a fair hearing (see subsection (6) of this section).

(5) A client who does not respond to the notice within twenty days is assigned to the PRR program. The department assigns the client to a PCP and pharmacy. The client may change the assigned PCP and pharmacy once within the initial sixty days. The assigned providers will be:

(a) Located in the client's local geographic area; and

(b) Reasonably accessible to the client.

(6) A client has ninety days to request a fair hearing. A client who requests a fair hearing within twenty days from the date they receive notice under subsection (4) of this section will not be assigned to the PRR program until a fair hearing decision is made. A client who requests a fair hearing after twenty days may have been assigned a PCP and pharmacist. An assigned client will remain in PRR until a fair hearing decision is made.

(7) When a PRR client chooses or the department assigns a PCP and pharmacy, the PCP and pharmacy requirements are:

(a) A PCP supervises and coordinates medical care for the client. The PCP makes referrals for specialist care and provides continuity of care. A PCP must be:

(i) A physician who meets the criteria under WAC 388-87-007; or

(ii) An advanced registered nurse practitioner (ARNP) who meets criteria under WAC 388-87-007; or

(iii) A licensed physician assistant, practicing with a sponsoring supervising physician.

(b) A single pharmacy fills all prescriptions for the client. For fee for service clients the pharmacy must be contracted with MAA.

(c) For clients enrolled in a managed care plan, the pharmacy and PCP must be contracted with the client's managed care plan.

(8) The PRR client's medical assistance identification card (MAID) will be marked in the "restricted" column.

(9) A client in PRR cannot change their PCP or pharmacy for twelve months unless the:

- (a) Client changes to a residence outside the provider's geographic area; or
- (b) PCP or pharmacy moves out of the client's geographical area; or
- (c) PCP or pharmacy refuses to continue as the client's provider; or
- (d) Client was assigned providers. The client may change the assigned providers once within sixty days of the initial assignment.

(10) A PRR client enrolled in a managed care plan must select a PCP and pharmacy from those identified as available within their plan. In addition to the reasons given in subsection (9) of this section, the client may change a provider if the:

(a) Chosen or assigned PCP or pharmacy no longer participates with their plan. The client may:

(i) Select a new PCP from the list of available PCPs provided by the plan; or

(ii) Transfer enrollment of all family members to the new department-contracted plan which the established PCP has joined.

(b) Client chooses a new plan during the managed care program's open enrollment period, which occurs during the twenty-four-month PRR enrollment period as defined in subsection (1) of this section.

(11) After twenty-four months, a PRR client's use of services is reviewed. A client is removed from PRR if:

(a) The billing records show the care received was reasonable and appropriate; or

(b) The PCP reports the services requested and received were reasonable and appropriate.

(12) If the client is not removed from PRR under subsection (11) of this section, the client continues to be in PRR for an additional twelve months. After that twelve-period, the client is reviewed again according to subsection (11)(a) and (b) of this section.

(13) Under the PRR program, MAA or the client's managed care plan will pay for only:

(a) Those services authorized by the PCP, the PCP-referred specialist, or the pharmacist; or

(b) Emergencies services; or

(c) Family planning services; or

(d) Women's health care services. A client enrolled with a managed care plan must self-refer to providers within the plan's network.

The client may be responsible for payment of services not covered by the PRR program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-501-0135, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.09.522. 97-03-038, § 388-501-0135, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0135, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-100.]

WAC 388-501-0150 Confidential records. The department shall consider medical and administrative records pertaining to applications and services rendered to clients confidential. The department shall prohibit disclosure of information contained in such records, files, papers and

communications except for purposes directly connected with the administration of the public assistance and medical care programs.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-035.]

WAC 388-501-0160 Exception to policy. A client request for an exception to policy for medical care services denied by strict application of a rule or regulation shall require approval by medical assistance administration. See WAC 388-200-1150 for exception to policy procedures.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-030.]

WAC 388-501-0165 Medical services request. (1) The department shall evaluate the request for medical services as described under chapter 388-86 WAC.

(2) The department shall base a decision to approve or deny a service on obtainable evidence that establishes whether the service is "medically necessary" as defined under WAC 388-500-0005.

(a) In each case, the department shall:

(i) Make an individualized decision whether a requested service is "medically necessary"; and

(ii) Base such decision only on information contained in the client's file.

(b) The evidence must be sufficient to determine that the requested service is or is not "medically necessary," and may include:

(i) A physiological description of the disease, injury, impairment, or other ailment;

(ii) Pertinent laboratory findings;

(iii) X-ray reports;

(iv) Patient profiles; and

(v) Other objective medical information, including but not limited to medically acceptable clinical findings and diagnoses resulting from physical or mental examinations.

(3) In deciding to approve or deny a durable medical equipment or prosthetic device request, the department shall give substantial weight to objective medical information, and conclusions based thereon, from an examining physician responsible for the client's diagnosis or treatment or both when:

(a) There is an uncontradicted and adequately substantiated conclusion of an examining physician that the requested service is "medically necessary." The department shall accept the examining physician's conclusion unless the department presents specific detailed reasons for rejecting that conclusion that are consistent with sound medical practice and supported by objective medical information in the client's file.

(b) Two or more examining physicians provide conflicting medical information on conclusions about whether the requested durable medical equipment or a prosthetic device is "medically necessary," the department may conclude the durable medical equipment or a prosthetic device is not "medically necessary" only if the department enumerates specific reasons for its conclusion that are supported by objective medical information in the client's file.

(4) The department shall deny a requested service when the service is:

(a) Not medically necessary as defined under WAC 388-500-0005;

(b) Generally regarded by the medical profession as experimental in nature or as unacceptable treatment; or

(c) Unless the client demonstrates through sufficient objective clinical evidence the existence of particular circumstances rendering the requested service medically necessary; or

(d) Not a covered service.

(5) The department shall:

(a) Approve or deny all requests for medical services within fifteen days of the receipt of the request; or

(b) Return a request to the requesting provider when the information submitted is insufficient for a determination of medical necessity and the requested service is a covered service. The department shall make a request for justifying additional information from the requesting provider within fifteen calendar days of the original receipt. If additional information is:

(i) Not received by the department within thirty days of the date requested, the department shall deny the original request within five days after the thirty-day period on the basis of insufficient justification of medical necessity;

(ii) Received by the department, the department shall make a final determination on the request within five working days of the receipt of the additional information.

(c) Send to the client a copy of the request for additional information justifying medical necessity for durable medical equipment or a prosthetic device.

(6) When the department denies a request for medical services, including all or part of a requested service, the department shall, within five working days of the decision, give the client and the provider written notice of the denial. The department shall ensure the notice states:

(a) The WAC references used as a basis for the decision;

(b) A summary statement of the specific facts the department relied upon for the decision;

(c) An explanation of the reasons for the denial, including the reasons why the specific facts relied on did not meet the requirements for approval;

(d) When required under subsection (3) of this section, a specific statement of the reasons and supporting facts for rejecting any medical information or conclusions of an examining physician;

(e) The client's right to a fair hearing if the request is made within ninety days of the receipt of the denial;

(f) The instructions on how to request the hearing;

(g) The client may be represented at the hearing by legal counsel or other representative;

(h) Upon the client's request, the name and address of the nearest legal services office; and

(i) If a fair hearing is requested, a medical assessment from other than the person involved in making the original decision may be obtained at the department's expense.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0165, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-038.]

(1999 Ed.)

WAC 388-501-0175 Medical care provided in bordering cities. (1) The department shall provide medical care to eligible Washington state residents in a bordering city on the same basis as in-state care.

(2) The only recognized bordering cities are:

(a) Coeur d'Alene, Moscow, Sandpoint, Priest River and Lewiston, Idaho; and

(b) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0175, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-130.]

WAC 388-501-0180 Out-of-state medical care. (1) A Washington state Medicaid client temporarily out of the state may be provided medical care within the scope of the Medicaid program.

(a) Residency requirements in WAC 388-505-0510 must be met.

(b) Medical assistance may be provided only in areas of Canada that border on the United States when no other resource is available.

(2) Persons eligible for the medically needy program may be provided medical care within the scope of that program.

(3) When an eligible person goes to another state, excluding bordering cities, expressly to obtain medical care that is available within the state of Washington, medical assistance will only be provided on an emergency basis.

(4) Medicaid will be provided to persons who enter the state and are determined to be financially eligible, provided the residency requirements in WAC 388-505-0510 are met.

(5) The department shall not provide medical care services out-of-state except in designated bordering cities under WAC 388-501-0175.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-501-0180, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-135 and 388-92-015.]

Chapter 388-502 WAC

ADMINISTRATION OF MEDICAL PROGRAMS— PROVIDERS

WAC

388-502-0205	Civil rights.
388-502-0210	Statistical data-vendor reports.
388-502-0220	Administrative appeal—Rate—Contractor/provider.
388-502-0230	Fair hearing—Providers.
388-502-0250	Interest penalties—Providers.

WAC 388-502-0205 Civil rights. (1) The department shall ensure all participating providers will not discriminate against any client because of race, creed, color, handicap or national origin in providing approved services.

(2) A provider shall not discriminate against any employee or applicant for employment because of race, creed, color, handicap, or national origin, except to the extent permitted by a bona fide occupational qualification.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0205, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-010 (part).]

WAC 388-502-0210 Statistical data-vendor reports.

(1) When requested by the department, all vendors under the

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program shall submit full reports of goods furnished and services rendered to the department in the manner specified. The department shall provide the vendor with standardized forms to report these data.

(2) The department shall tabulate and analyze the data collected to secure statistics on costs of and the services rendered in the various phases of the program. The department shall make available such tabulations and analyses to the department's advisory committee, state welfare medical care committee, official organizations of vendor groups participating in the program, and other appropriate persons or groups.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-020.]

WAC 388-502-0220 Administrative appeal—Rate

Contractor/provider. (1) Right to an administrative appeal. Any enrolled contractor/provider of medical services, except nursing facilities governed by WAC 388-96-904, shall have a right to an administrative appeal any time the contractor/provider disagrees with the reimbursement rate.

(2) First level of appeal. A contractor/provider wishing to contest an action described in subsection (1) of this section files an appeal with the medical assistance administration (MAA).

(a) Unless a written rate notification specifies otherwise, the department shall make retroactive rate adjustments only when a contractor/provider files a rate appeal. The rate appeal requesting retroactive rate adjustment shall be made within sixty calendar days after being notified of an action or determination the contractor/provider wishes to challenge. The notification date of an action or determination shall be the date of the written rate notification letter. The department shall not consider for retroactive adjustments, a contractor/provider rate adjustment appeal filed after the sixty-day period described in this subsection.

(b) The appeal shall include a statement of the specific issue being appealed, supporting documentation, and a request for recalculation of the rate. MAA may request additional documentation to complete the review. MAA may conduct an audit of the documentation provided in order to complete the review.

(c) When a portion of a rate is appealed, MAA may review all components of the reimbursement rate.

(d) MAA shall issue a decision or request additional information within sixty calendar days of the receipt of the rate appeal request. When additional information is necessary, the contractor/provider shall have forty-five calendar days to submit the information. MAA shall issue a decision within thirty calendar days of receipt of complete information.

(e) Unless the written rate notification specifies otherwise, increases in rates resulting from an appeal shall be effective retroactively to the effective date of the rate change. The appeal shall be filed within sixty calendar days after the written rate notification letter that the contractor/provider is challenging. Increases in rates, resulting from a rate appeal filed after the sixty-day period described under (a) of this subsection, shall be effective the date the appeal is filed with MAA. Appeals resulting in rate decreases shall be effective

on the date specified in the appeal decision notification. The effective date shall not be before the date of the appeal decision notification. Rate changes subject to the provisions of fraudulent practices as described under RCW 74.09.210 are exempt from these provisions.

(f) MAA may grant extensions of time at MAA's discretion if requested within the sixty-day period referenced under (a) of this subsection.

(3) Second level of appeal. When the contractor/provider disagrees with an adverse rate review decision, the contractor/provider may file a request for a dispute conference with the MAA. "Dispute conference" for this section means an informal administrative hearing for the purpose of resolving contractor/provider disagreements with any of the department actions, described under subsection (1) of this section, not resolved at the first level of appeal. The dispute conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(a) A contractor/provider shall file a request for a dispute conference within thirty calendar days following receipt of the adverse review decision. The department shall not consider dispute conference requests submitted after the thirty-day period of the first level decision date.

(b) MAA shall conduct the dispute conference within ninety calendar days of the receipt of request.

(c) The conference chairperson shall issue the final decision within thirty calendar days of the conference.

(d) MAA may grant extensions of time for extenuating circumstances.

(e) The effective date of dispute conference decisions regarding rate changes shall be the same as specified under subsection (2)(e) of this section.

(f) The dispute conference shall be the final level of administrative appeal within the department and precede judicial action.

(4) MAA shall construe failure on the part of the contractor/provider to attempt to resolve disputed rates as provided in this section as an abandonment of the dispute.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-042.]

WAC 388-502-0230 Fair hearing—Providers. A certified provider of medical care services who is assessed a civil penalty under RCW 74.09.210 or otherwise served with notice that repayment of excess benefits is due under RCW 74.09.210, shall have the right to a fair hearing as provided by chapter 388-08 WAC.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-502-0230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-042.]

WAC 388-502-0250 Interest penalties—Providers.

(1) The department shall assess interest on amounts of excess benefits or payments a certified provider of medical services receives:

(a) Who is found liable for receipt of excess payments under RCW 74.09.220;

(b) Otherwise served with notice that repayment of excess benefits is due under RCW 74.09.220; or

(c) Except for nursing homes which are governed by WAC 388-96-310.

(2) Under RCW 74.09.220, the department shall assess interest on excess benefits or payments at the rate of one percent each month from the date upon which payment was made to the date upon which repayment is made to the state. Interest does not apply when the excess benefits or payments were obtained as a result of errors made by the department.

(3) The department shall ensure:

(a) Interest amounts will be clearly identified in all overpayment communications; and

(b) A daily interest accrual amount will be identified and accrued until the day immediately preceding the day the full repayment check is mailed to the state.

(4) When repayment is made through the recoupment process (payments are withheld from current bills until the overpayment amount is met), the department shall ensure interest accrues to the date recoupment is finalized.

[Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-502-0250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-044.]

Chapter 388-503 WAC PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE

WAC

388-503-0310	Categorically needy eligible persons.
388-503-0505	General eligibility requirements for medical programs.
388-503-0510	How a client is determined "related to" a categorical program.
388-503-0515	Medical coverage resulting from a cash grant.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-503-0305	Program priorities. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-503-0305, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.
388-503-0320	Medically needy eligible persons. [Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. 95-24-017 (Order 3921, #100267), § 388-503-0320, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-503-0320, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-005 and 388-99-010.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0100.
388-503-0350	Medical care services—GAU/ADATSA. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-503-0350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-126 and 388-83-006.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0110 and 388-529-0100.
388-503-0370	Medically indigent eligible persons. [Statutory Authority: RCW 74.08.090, 95-22-039 (Order 3913, #100246), § 388-503-0370, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-503-0370, filed 5/3/94, effective 6/3/94. Formerly WAC 388-100-005 (part.)] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-505-0110, 388-519-0300 and 388-438-0100.

WAC 388-503-0310 Categorically needy eligible persons. A person eligible for categorically needy medical assistance is:

(1999 Ed.)

(1) Not eligible for or receiving temporary assistance for needy families (TANF) cash benefits but who meets the eligibility criteria for aid to families with dependent children (AFDC) that were in effect on July 16, 1996 except the person's:

(a) Earned income is treated as described under WAC 388-507-0740; and

(b) Resources are treated as described under WAC 388-505-0580.

This group shall include, but is not limited to, the special situations described under WAC 388-507-0740.

(2) Receiving or eligible to receive a cash assistance payment under:

(a) TANF. For the purpose of determining eligibility for a medical program, any reference to AFDC includes TANF; or

(b) Supplemental security income (SSI) including a grandfathered person and a person with an essential spouse; or

(c) State supplemental payment (SSP) to a person as assistance based on need in supplementation of SSI benefits. This payment includes mandatory state supplement or optional state supplement as defined under WAC 388-500-005. The ineligible spouse of an SSI beneficiary receiving a state supplement payment for the ineligible spouse is not eligible for noninstitutional categorically needy medical assistance.

(3) A person twenty years of age or younger who:

(a) Meets the one-person TANF financial requirements and is in:

(i) A nursing facility or intermediate care facility for mentally retarded (ICF/MR); or

(ii) An approved inpatient psychiatric facility.

(b) Is in foster care; or

(c) Receives subsidized adoption.

(4) A current client of Title II, Social Security Administration (SSA) benefits who:

(a) Was a concurrent client of Title II and SSI benefits;

(b) Is ineligible for SSI benefits and/or state supplementary payments; and

(c) Would be eligible for SSI benefits if the department deducts the following from the current Title II benefit amount:

(i) All Title II cost-of-living benefit increases under P.L. 94-566, Section 503 received by the client since termination from SSI/SSP; and

(ii) All Title II cost-of-living benefit increases received during the time period in subsection (4)(c)(i) of this section by the client's spouse and/or other financially responsible family member living in the same household.

(5) An SSI client, after January 1, 1981, who continues to be eligible for medical assistance under P.L. 96-265 and 99-643;

(6) A currently disabled client receiving widow's or widower's benefits under Section 202 (e) or (f) of the Social Security Act if the disabled client:

(a) Was entitled to a monthly insurance benefit under Title II of the Social Security Act for December 1983;

[Title 388 WAC—p. 621]

(b) Was entitled to and received a widow's or widower's benefit based on a disability under Section 202 (e) or (f) of the Social Security Act for January 1984;

(c) Became ineligible for SSI/SSP in the first month in which the increase provided under Section 134 of P.L. 98-21 was paid to the client;

(d) Has been continuously entitled to a widow's or widower's benefit under Section 202 (e) or (f) of the act;

(e) Would be eligible for SSI/SSP benefits if the amount of that increase, and any subsequent cost-of-living increases provided under Section 215(i) of the act, were disregarded;

(f) Is fifty through fifty-nine years of age; and

(g) Filed an application for Medicaid coverage before July 1, 1988.

(7) Any person receiving Title II disabled widow/widower benefits (DWB) under Section 202 (e) or (f) of the SSA, if the person:

(a) Is not eligible for the hospital insurance benefits under Medicare Part A of Title XVIII;

(b) Received SSI/SSP payments in the month before receiving such Title II benefits;

(c) Became ineligible for SSI/SSP due to receipt of or increase in such Title II benefits; and

(d) Would be eligible for SSI/SSP if the amount of such Title II benefits or increase in such Title II benefits under Section 202 (e) or (f) of the SSA, and any subsequent cost-of-living increases provided under Section 215(i) of the act were disregarded.

(8) A disabled or blind client receiving Title II Disabled Adult Childhood (DAC) benefits under Section 202(d) of the SSA if the client:

(a) Has attained eighteen years of age;

(b) Lost SSI/SSP on or after July 1, 1988, due to receipt of or increase in DAC benefits; and

(c) Would be eligible for SSI/SSP if the amount of the DAC benefits or increase under Section 202(d) of the SSA and any subsequent cost-of-living increases provided under Section 215(i) of the SSA Act were disregarded.

(9) A client who:

(a) In August 1972, received:

(i) Old age assistance (OAA);

(ii) Aid to blind (AB);

(iii) Aid to families with dependent children (AFDC); or

(iv) Aid to the permanently and totally disabled (APTD);

(b) Was entitled to or received retirement, survivors, and disability insurance (RSDI) benefits; or

(c) Is ineligible for OAA, AB, AFDC, SSI or APTD solely because of the twenty percent increase in Social Security benefits under P.L. 92-336.

(10) A pregnant woman whose family income is at or below one hundred eighty-five percent of the Federal Poverty Level (FPL), or postpartum woman as described under WAC 388-508-0830;

(11) A child, born to a woman eligible for and receiving medical assistance on the date of the child's birth, from the date of birth for a period of one year when the child remains a member of the mother's household;

(12) A child under age nineteen meeting residence, citizenship, and Social Security number requirements whose

countable family income is at or under two hundred percent of the FPL.

(13) A family member who is ineligible for medical assistance because of the collection or increased collection of child or spousal support. The family is eligible for medical assistance for four months beginning with the month of ineligibility if the family received medical assistance in at least three of the six months immediately preceding the month of ineligibility;

(14) Denied TANF cash payments solely because of a departmental recovery of an overpayment;

(15) In a medical facility and:

(a) Who would be eligible for cash assistance if the person was not institutionalized; or

(b) Is an SSI-related institutionalized person and has gross income above the cash assistance level but below three hundred percent of the Federal Benefit Rate as defined under WAC 388-250-1700.

(16) Sixty-five years of age or older, a patient in an institution for mental diseases (IMD), and is resource and income eligible as described under subsection (15)(a) or (b) of this section;

(17) Eligible for and accepting hospice services as described under WAC 388-86-047 and who is:

(a) SSI categorically related with gross income less than three hundred percent of the SSI Federal Benefit Rate; or

(b) AFDC or TANF categorically related.

(18) Blind or presumptively disabled under SSI criteria, as described under WAC 388-511-1105, and the person receives continuing general assistance (GA-X) cash assistance;

(19) An alien ineligible for TANF or SSI cash assistance because of deeming of income of the alien's sponsors as described under WAC 388-218-1695;

(20) A client who:

(a) Was entitled to RSDI benefits in August 1972; and

(b) Is ineligible for TANF or SSI solely because of the twenty percent increase in Social Security benefits under PL 92-336.

(21) A child who received SSI payments on August 22, 1996, and who, but for the change in disability criteria would continue to be eligible for SSI benefits;

(22) Not an inmate of a public institution.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-503-0310, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090 and 74.04.050. 97-03-036, § 388-503-0310, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090 and SPA 95-11. 96-12-001 (Order 3981), § 388-503-0310, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090. 94-17-036 (Order 3769), § 388-503-0310, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-503-0310, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-82-010 and 388-82-115.]

WAC 388-503-0505 General eligibility requirements for medical programs. (1) Persons applying for benefits under the medical coverage programs established under chapter 74.09 RCW must meet the eligibility criteria established by the department in chapters 388-400 through 388-555 WAC.

(2) Persons applying for medical coverage are considered first for federally funded or federally matched programs. State-funded programs are considered after federally funded programs are not available to the client except for brief periods when the state-funded programs offer a broad scope of care which meet a specific client need.

(3) Unless otherwise specified in program specific WAC, the eligibility criteria for each medical program are as follows:

- (a) Verifiable of age and identity (chapters 388-404, 388-406, and 388-490 WAC); and
- (b) Residence in Washington state (chapter 388-468 WAC); and
- (c) Citizenship or immigration status in the United States (chapter 388-424 WAC); and
- (d) Possession of a valid Social Security Account Number (chapter 388-474 WAC); and
- (e) Assignment of medical support rights to the state of Washington (WAC 388-505-0540); and
- (f) Cooperation in securing medical support (chapter 388-422 WAC); and
- (g) Countable resources which are within program limits (chapters 388-470 and 388-478 WAC); and
- (h) Countable income which are within program limits (chapters 388-450 and 388-478 WAC).

(4) In addition to the general eligibility requirements in subsection (3) of this section, each program has specific eligibility requirements as described in applicable WAC.

(5) Persons living in correctional institutions are not eligible for the department's medical coverage programs.

(6) Persons terminated from SSI or TANF cash grants and those who lose eligibility for categorically needy (CN) medical coverage have their CN coverage extended while their eligibility for other medical programs is redetermined. This extension of medical coverage is described in chapter 388-434 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0505, filed 7/31/98, effective 9/1/98. Formerly WAC 388-501-0110, 388-503-0305 and 388-505-0501.]

WAC 388-503-0510 How a client is determined "related to" a categorical program. (1) A person is related to the Supplemental Security Income (SSI) program if they are:

- (a) Aged, blind, or disabled as defined in WAC 388-511-1105(1); or
- (b) Considered as eligible for SSI under WAC 388-511-1105(5); or
- (c) Children meeting the requirements of WAC 388-505-0210(6).

(2) A person or family is considered to be related to the temporary assistance for needy families (TANF) program or the state-funded assistance (SFA) program if they meet:

(a) The program requirements for the TANF or the SFA cash assistance programs or the requirements of WAC 388-505-0220, 388-505-0210 (3) or (4), or 388-503-0310 (17)(b); or

(b) Would meet such requirements except that:

(i) The assistance unit's countable income exceeds the TANF or the SFA program standards in chapter 388-478 WAC; or

(ii) The assistance unit's countable resources exceed the cash program standards in chapter 388-470 WAC.

(3) Persons related to SSI or to TANF are eligible for categorically needy (CN) or medically needy (MN) medical coverage if they meet the other eligibility criteria for these medical programs. See chapters 388-505 and 388-519 WAC for these eligibility criteria.

(4) Persons related to SSI or to TANF and who receive the related CN medical coverage have redetermination rights as described in WAC 388-503-0505(6).

(5) Persons related to SFA are eligible for state-funded medical coverage as long as they meet the other eligibility criteria for the medical program. The state-funded medical coverage has the same scope of coverage as CN or MN coverage described in subsection (3) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0510, filed 7/31/98, effective 9/1/98.]

WAC 388-503-0515 Medical coverage resulting from a cash grant. (1) Families or individuals eligible for SSI, SSI state supplement or TANF cash grants are automatically eligible for categorically needy (CN) medical coverage. These clients receive medical coverage benefits without making a separate application. Certification for CN medical coverage parallels that for the cash benefits.

(2) Upon termination of cash benefits as described in subsection (1) of this section, medical coverage continues until the client's eligibility for other medical coverage can be completed. Continuing medical coverage is terminated if the client does not cooperate with the eligibility re-determination process.

(3) Families or individuals eligible for or related to state financial assistance (SFA) cash grants are eligible for state-funded medical coverage. For this program, the term "related-to" is defined parallel to WAC 388-503-0510(2). The scope of medical coverage parallels that for the federally funded CN program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-503-0515, filed 7/31/98, effective 9/1/98.]

Chapter 388-505 WAC

FAMILY MEDICAL

WAC

388-505-0110	Medical assistance coverage for adults not covered under family medical programs.
388-505-0210	Children's medical eligibility.
388-505-0220	Family medical eligibility.
388-505-0540	Assignment of rights and cooperation.
388-505-0595	Trusts.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-505-0501	Eligibility—General. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0501, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-015.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-503-0505.
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388-505-0505	Age. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.
388-505-0510	Residence. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2), 97-15-025, § 388-505-0510, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-025.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-468-0010.
388-505-0520	Citizenship. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997, 98-15-066, § 388-505-0520, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090, 96-13-002 (Order 3983), § 388-505-0520, filed 6/6/96, effective 7/7/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18, 95-24-016 (Order 3923), § 388-505-0520, filed 11/22/95, effective 12/23/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0520, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-015.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-424-0005 and 388-424-0010.
388-505-0530	Social Security number. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-017.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-476-0005.
388-505-0560	Cooperation in securing medical support. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0560, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-013.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-472-0005, 388-505-0540, 388-422-0005, 388-422-0010 and 388-422-0020.
388-505-0570	Good cause for noncooperation—Medical care support. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0570, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-014.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-422-0020(4)c.
388-505-0580	Resources. [Statutory Authority: RCW 74.08.090, 96-01-005 (Order 3932, # 100268), § 388-505-0580, filed 12/6/95, effective 1/6/96; 95-02-026 (Order 3817), § 388-505-0580, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-505-0580, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-026.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-470-0015, 388-470-0020, 388-470-0040, 388-488-0005 and 388-450-0210.
388-505-0590	Income. [Statutory Authority: RCW 74.08.090, 95-17-031 (Order 3878), § 388-505-0590, filed 8/9/95, effective 9/9/95; 95-04-047 (Order 3827), § 388-505-0590, filed 1/25/95, effective 2/25/95; 94-10-065 (Order 3732), § 388-505-0590, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-041.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0005, 388-450-0015, 388-450-0210 and 388-450-0215.

WAC 388-505-0110 Medical assistance coverage for adults not covered under family medical programs. (1) An adult who does not meet the institutional status require-

ments as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for categorically needy (CN) coverage under this chapter. Persons excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section a person is eligible for CN coverage when the person:

- (a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and
- (b) Has CN countable income and resources that do not exceed the income and resource standards in WAC 388-478-0080; and
- (c) Is sixty-five years of age or older, or meets the blind and/or disability criteria of the federal SSI program.

(2) An adult not meeting the conditions of subsection (1)(b) is eligible for CN medical coverage if the person:

- (a) Is a current beneficiary of Title II of the Social Security Act (SSA) benefits who:
 - (i) Was a concurrent beneficiary of Title II and Supplemental Security Income (SSI) benefits;
 - (ii) Is ineligible for SSI benefits and/or state supplementary payments (SSP); and
 - (iii) Would be eligible for SSI benefits if certain cost-of-living (COLA) increases are deducted from the client's current Title II benefit amount:
 - (A) All Title II COLA increases under P.L. 94-566, section 503 received by the client since their termination from SSI/SSP; and
 - (B) All Title II COLA increases received during the time period in subsection (1)(d)(iii)(A) of this section by the client's spouse or other financially responsible family member living in the same household.
- (b) Is an SSI beneficiary, no longer receiving a cash benefit due to employment, who meets the provisions of section 1619(b) of Title XVI of the SSA;
- (c) Is a currently disabled client receiving widow's or widower's benefits under section 202 (e) or (f) of the SSA if the disabled client:
 - (i) Was entitled to a monthly insurance benefit under Title II of the SSA for December 1983; and
 - (ii) Was entitled to and received a widow's or widower's benefit based on a disability under section 202 (e) or (f) of the SSA for January 1984;
 - (iii) Became ineligible for SSI/SSP in the first month in which the increase provided under section 134 of P.L. 98-21 was paid to the client;
 - (iv) Has been continuously entitled to a widow's or widower's benefit under section 202 (e) or (f) of the SSA;
 - (v) Would be eligible for SSI/SSP benefits if the amount of that increase, and any subsequent COLA increases provided under section 215(i) of the SSA, were disregarded;
 - (vi) Is fifty through fifty-nine years of age; and
 - (vii) Filed an application for Medicaid coverage before July 1, 1988.
- (d) Was receiving, as of January 1, 1991, Title II disabled widow or widower benefits under section 202 (e) or (f) of the SSA if the person:

(i) Is not eligible for the hospital insurance benefits under Medicare Part A;

(ii) Received SSI/SSP payments in the month before receiving such Title II benefits;

(iii) Became ineligible for SSI/SSP due to receipt of or increase in such Title II benefits; and

(iv) Would be eligible for SSI/SSP if the amount of such Title II benefits or increase in such Title II benefits under section 202 (e) or (f) of the SSA, and any subsequent COLA increases provided under section 215(i) of the act were disregarded.

(e) Is a disabled or blind client receiving Title II Disabled Adult Childhood (DACP) benefits under section 202(d) of the SSA if the client:

(i) Is at least eighteen years old;

(ii) Lost SSI/SSP benefits on or after July 1, 1988, due to receipt of or increase in DACP benefits; and

(iii) Would be eligible for SSI/SSP if the amount of the DACP benefits or increase under section 202(d) of the DACP and any subsequent COL increases provided under section 215(i) of the SSA were disregarded.

(f) Is a client who:

(i) In August 1972, received:

(A) Old age assistance (OAA);

(B) Aid to blind (AB);

(C) Aid to families with dependent children (AFDC); or

(D) Aid to the permanently and totally disabled (APTD);

and

(ii) Was entitled to or received retirement, survivors, and disability insurance (RSDI) benefits; or

(iii) Is eligible or OAA, AB, AFDC, SSI, or APRD solely because of the twenty percent increase in Social Security benefits under P.L. 92-336.

(3) An adult who does not meet the institutional status requirement as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for medically needy (MN) coverage under this chapter. Persons excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section a person is eligible for MN coverage when the person:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has MN countable income that does not exceed the income standards in WAC 388-478-0070, or meets the excess income spenddown requirements in WAC 388-519-0110; and

(c) Meets the countable resource standards in WAC 388-478-0070; and

(d) Is sixty-five years of age or older or meets the blind and/or disability criteria of the federal SSI program.

(4) MN coverage is available for an aged, blind, or disabled ineligible spouse of an SSI recipient. See WAC 388-519-0100 for additional information.

(5) An adult may be eligible for the alien emergency medical program as described in WAC 388-438-0110.

(6) An adult is eligible for the state-funded general assistance - expedited Medicaid disability (GA-X) program when they:

(a) Meet the requirements of the cash program in WAC 388-400-0025 and 388-478-0030; or

(b) Meet the SSI-related disability standards but cannot get the SSI cash grant due to immigration status or sponsor deemed issues.

Clients may be eligible for GA cash benefits and CN medical coverage due to different sponsor deemed requirements.

(7) An adult is eligible for the state-funded medical care services (MCS) program when the person is eligible for GAU or ADATSA program coverage as described in WAC 388-478-0030.

(8) An adult is eligible for the state-funded medical indigent (MI) program when the person meets the requirements listed in WAC 388-438-0100.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-505-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0350 and 388-503-0370.]

WAC 388-505-0210 Children's medical eligibility.

(1) A child is eligible for newborn categorically needy (CN) children's medical assistance when:

(a) The child's mother, was eligible for and receiving medical assistance at the time of the child's birth; and

(b) The child is under one year of age; and

(c) The child remains with the mother and resides in the state.

(2) Children under the age of nineteen are eligible for CN medical assistance when they:

(a) Meet the requirements of:

(i) Citizenship or immigrant status as described in chapter 388-424 WAC; and

(ii) State residence as described in chapter 388-468 WAC; and

(iii) Social security number as described in chapter 388-476 WAC; and

(b) Meet family income levels described in WAC 388-478-0075; or

(c) Meet the requirements of WAC 388-505-0220 or 388-523-0100.

(3) Children under the age of twenty-one are eligible for CN medical assistance when they:

(a) Meet citizenship or immigrant status, state residence, and social security number requirements as described in subsection (2)(a) of this section; and

(b) Meet income levels described in WAC 388-478-0075 when income is counted according to WAC 388-408-0055 (1)(c); and

(c) Reside in an institution (medical hospital, intermediate care facility for mentally retarded (ICF/MR), or nursing home facility) as described in WAC 388-513-1320 for more than thirty days; or

(d) Reside in a psychiatric or chemical dependency facility as described in WAC 388-513-1320.

(4) Children under the age of twenty-one are eligible for CN if they:

(a) Are in foster care; or

(b) Receive subsidized adoption.

(5) Children, regardless of age, are eligible for CN medical if they are eligible to receive Supplemental Security Income (SSI) payments based upon their own disability.

(6) Children are eligible for CN medical if they received SSI payments for August 1996, and except for the passage of amendments to federal disability definitions would be eligible for SSI.

(7) Children under the age of nineteen are eligible for Medically Needy (MN) medical assistance when they:

(a) Meet citizenship, state residence and social security number requirements as described in subsection (2)(a); and

(b) Have income at or above the income levels described in WAC 388-478-0070.

(8) A child is eligible for SSI-related MN when:

(a) They meet the conditions in subsection (7)(a) and (b); and

(b) They meet the blind and/or disability criteria of the federal SSI program.

(9) Children under the age of eighteen are eligible for the state funded children's health program, if they:

(a) Are ineligible for any CN medical program; and

(b) Meet income levels described in WAC 388-478-0075.

(10) There are no resource standards for either the children's CN or the state funded children's health programs.

(11) The requirements in WAC 388-503-0505 (3)(c) and (d) do not apply to persons applying for the state funded children's health program.

(12) Children may also be eligible for:

(a) Temporary assistance for needy families (TANF) or state funded assistance (SFA)-related medical as described in WAC 388-505-0220; and

(b) TANF/SFA-related medical extensions as described in WAC 388-523-0100.

(13) Except for a client in subsection (3)(c) and (d), an inmate of a public institution, as defined in WAC 388-500-0005, is not eligible for CN or MN medical coverage.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-505-0210, filed 7/31/98, effective 9/1/98. Formerly WAC 388-509-0905, 388-509-0910 and 388-509-0920.]

WAC 388-505-0220 Family medical eligibility. (1) A person is eligible for categorically needy (CN) medical coverage when they are:

(a) Receiving temporary assistance for needy families (TANF) cash benefits; or

(b) Receiving cash diversion assistance described in chapter 388-222 WAC; or

(c) Eligible for TANF but chooses not to receive cash benefits; or

(d) Not eligible for or receiving TANF cash assistance, but meets the eligibility criteria for aid to families with dependent children (AFDC) that were in effect on July 16, 1996 except:

(i) Earned income is treated as described in WAC 388-450-0210; and

(ii) Resources are treated as described in WAC 388-470-0005 for applicants and 388-470-0050 for recipients.

(2) A person is eligible for CN medical coverage when they are not eligible for or receiving cash benefits solely for one of the following reasons:

(a) Received sixty months of TANF cash benefits or is a member of an assistance unit which has received sixty months of TANF cash benefits; or

(b) Failed to meet the school attendance requirement in chapter 388-400 WAC; or

(c) Is an unmarried minor parent not in a department-approved living situation; or

(d) Is a parent or caretaker relative who fails to notify the department within five days of the date the child leaves the home and the child's absence will exceed ninety days; or

(e) Is a fleeing felon or fleeing to avoid prosecution for a felony charge, or a probation and parole violator; or

(f) Was convicted of a drug related felony; or

(g) Was convicted of receiving benefits unlawfully; or

(h) Was convicted of misrepresenting residence to obtain assistance in two or more states; or

(i) Has gross earnings exceeding the TANF gross income level; or

(j) Does not meet work quarter requirements; or

(k) Does not meet the unemployment requirement; or

(l) Is not cooperating with WorkFirst requirements.

(3) A person is eligible for SFA medical when:

(a) Eligible for or receiving SFA cash benefits; or

(b) Receiving SFA cash diversion assistance described in chapter 388-222 WAC; or

(c) Is not eligible for or receiving SFA solely due to factors described in subsection (2) of this section; or

(d) Meets the criteria of (1)(d) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-505-0220, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0740 and 388-522-2210.]

WAC 388-505-0540 Assignment of rights and cooperation. (1) When a person becomes eligible for any of the department's medical programs, they make assignment of certain rights to the state of Washington. This assignment includes all rights to any type of coverage or payment for medical care which results from:

(a) A court order;

(b) An administrative agency order; or

(c) Any third-party benefits or payment obligations for medical care which are the result of **subrogation** or contract (see WAC 388-87-020).

(2) **Subrogation** is a legal term which describes the method by which the state acquires the rights of a client for whom or to whom the state has paid benefits. The subrogation rights of the state are limited to the recovery of its own costs.

(3) The person who signs the application makes the assignment of rights to the state. Assignment is made on their own behalf and on behalf of any eligible person for whom they can legally make such assignment.

(4) A person must cooperate with the department in the identification, use or collection of third-party benefits. Failure to cooperate results in a termination of eligibility for the responsible person. Other obligations for cooperation are located in chapters 388-14 and 388-422 WAC. The following

clients are exempt from termination of eligibility for medical coverage as a result of noncooperation:

- (a) A pregnant woman, and
- (b) Minor children, and

(c) A person who has been determined to have "good cause" for noncooperation (see WAC 388-422-0015).

(5) A person will not lose eligibility for medical assistance programs due solely to the noncooperation of any third party.

(6) A person will be responsible for the costs of otherwise covered medical services if:

- (a) The person received and kept the third-party payment for those services; or

- (b) The person refused to provide to the provider of care their legal signature on insurance forms.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-505-0540, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.09.522. 97-04-005, § 388-505-0540, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-505-0540, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-012, 388-501-0170 and 388-505-0560.]

WAC 388-505-0595 Trusts. (1) For the purposes of this section, the department shall ensure a trust includes any legal instrument similar to a trust.

(2) The department shall ensure this section shall not apply to any trust or initial trust decree established:

- (a) On or before April 6, 1986; and

- (b) Solely for the benefit of a client who lives in an intermediate care facility for the mentally retarded (ICFMR).

(3) For trusts established on or before August 10, 1993, the department shall:

- (a) Determine if the trust is established by the client, client's spouse, or the legal guardian for a client under which:

- (i) The client may be the beneficiary of all or part of the payments from the trust;

- (ii) The distribution of such payments is determined by one or more of the trustees; and

- (iii) The trustees are permitted to use discretion with respect to the distribution of payments to the client;

- (b) Consider available to the client the greatest amount of payments permitted to be distributed under the terms of the trust when the conditions defined under (a) of this subsection exist;

- (c) Apply (b) of this subsection whether or not:

- (i) The trust:

- (A) Is irrevocable; or

- (B) Is established for purposes other than to establish eligibility for medical assistance;

- (ii) The trustees actually use the discretion permitted by the trust.

- (d) For an irrevocable trust not meeting the description under (a) of this subsection, consider:

- (i) The trust as an unavailable resource when the client establishes the trust for a beneficiary other than the client or the client's spouse;

- (ii) As an available resource the amount of the trust's assets:

- (A) The client may access; or

- (B) The trustee of the trust distributes as actual payments to the client.

(1999 Ed.)

(iii) Referencing WAC 388-513-1365 for regulations concerning the transfer of assets;

- (e) For a revocable trust, consider:

- (i) The full amount of the trust as an available resource of the client when the trust is established by:

- (A) The client;

- (B) The client's spouse and the client lives with the spouse;

- (C) A person other than the client or the client's spouse only to the extent the client has access to the assets of the trust.

(ii) Only the amounts paid to the client from the trust as an available resource when the trust is established by:

- (A) The client's spouse and the client does not live with the spouse; or

- (B) A person other than the client or the client's spouse and payments are distributed by a trustee of the trust.

(f) Not consider client withdrawal of funds from a trust as described under (e) of this subsection as income;

(g) Waive the requirements of this subsection (3) if undue hardship exists. Undue hardship includes but is not limited to situations in which:

- (i) The trustee refused to disburse the funds from the trust and the client has filed and is actively pursuing litigation to require the trustee to disburse said funds; or

- (ii) The client would be forced to go without life sustaining services because trust funds are not made available to pay for the services.

(4) For trusts established on or after August 11, 1993, the department shall follow subsection (3) of this section to determine eligibility for medical services received on or before September 30, 1993.

(5) For trusts established on or after August 11, 1993, the department shall follow subsections (6) through (14) of this section to determine eligibility for medical services received on or after October 1, 1993.

(6) The department shall consider a trust established by the client when:

- (a) All or part of the assets, as defined under WAC 388-513-1365, of the trust were from the client; and

- (b) The trust was established, other than by will, by:

- (i) The client or the client's spouse;

- (ii) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the client or the client's spouse; or

- (iii) A person, including a court or administrative body, acting at the direction of or upon the request of the client or the client's spouse.

(7) The department shall consider available to the client only the assets contributed to the trust by the client when part of the trust assets were contributed by any other person.

(8) The department shall not consider:

- (a) The purposes for which a trust is established;

- (b) Whether the trustees have or exercise any discretion under the terms of the trust;

- (c) Restrictions on when or whether distributions may be made from the trust; or

- (d) Restrictions on the use of distributions from the trust.

(9) For a revocable trust established as described under subsection (6) of this section, the department shall consider:

[Title 388 WAC—p. 627]

(a) The full amount of a revocable trust as an available resource of the client;

(b) Payments from the trust to or for the benefit of the client as income of the client; and

(c) Any payments from the trust other than payments described under (b) of this subsection as a transfer of client assets.

(10) For an irrevocable trust established as described under subsection (6) of this section, the department shall consider:

(a) As an available resource to the client, the portions of a trust or the income from the trust from which payment can be made to or for the benefit of the client. When payment is made from such irrevocable trust, the department shall consider such payments as:

(i) Income to the client when payment is to or for the client's benefit; or

(ii) The transfer of an asset when payment is made to any person for any purpose other than the client's benefit;

(b) As a transfer of assets, a trust from which a payment cannot be made to or for the client's benefit. For such trust the department shall find:

(i) The transfer of assets is effective the date:

(A) Of the establishment of the trust; or

(B) On which payment to the client is precluded, if later;

(ii) The value of the trust includes any payments made from the trust after the effective date of the transfer.

(11) For a revocable or irrevocable trust established by persons or with funds other than as described under subsection (6) of this section, the department shall consider such trust under subsection (3)(e) of this section.

(12) The department shall not follow subsections (6) through (11) of this section for a trust containing the assets of a person:

(a) Sixty-four years of age and younger who is disabled as defined by SSI criterion and the trust:

(i) Is established for the benefit of such person by such person's parent, grandparent, legal guardian, or a court; and

(ii) Stipulates that the state will receive all amounts remaining in the trust upon the death of the client up to the amount of Medicaid expended on the client's behalf.

(b) Regardless of age, who is disabled as defined by SSI criteria and the trust:

(i) Is managed by a nonprofit association which:

(A) Maintains separate accounts for each trust beneficiary; and

(B) May pool such separate accounts only for investment and fund management purposes.

(ii) Stipulates that the state will receive all amounts remaining in the client's trust account upon the death of the client up to the amount of Medicaid expended on the client's behalf.

(13) The department shall waive the application of this section if the client establishes undue hardship exists. Undue hardship includes, but is not limited to, situations where the client would be forced to go without life sustaining services.

(14) See WAC 388-513-1365 for trusts the department determines is a transfer of assets under this section.

[Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-505-0595, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-041.]

Chapter 388-506 WAC

MEDICAL FINANCIAL RESPONSIBILITY

WAC

388-506-0620 SSI-related medical clients.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-506-0610 AFDC-related medical programs. [Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48, 95-19-007 (Order 3895), § 388-506-0610, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090, 95-10-025 (Order 3847), § 388-506-0610, filed 4/26/95, effective 5/27/95; 94-17-034 (Order 3767), § 388-506-0610, filed 8/10/94, effective 9/10/94; 94-10-065 (Order 3732), § 388-506-0610, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-046 and 388-99-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-408-0055, 388-450-0005 and 388-470-0070.

388-506-0630 SSI-related income deemed. [Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160, 97-10-022, § 388-506-0630, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-506-0630, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-92-027 and 388-99-020.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-408-0055 and 388-450-0150.

WAC 388-506-0620 SSI-related medical clients. (1) The department shall consider income and resources for an institutionalized:

(a) Child as described under WAC 388-513-1315(6); or
(b) Spouse as described under WAC 388-513-1330 and 388-513-1350.

(2) The department shall consider the income and resources of spouses as available to each other through the month in which the spouses stopped living together. See WAC 388-513-1330 and 388-513-1350 when a spouse is institutionalized.

(3) The department shall follow WAC 388-515-1505, 388-515-1510, or 388-515-1530 when one or both spouses are receiving community options program entry system (COPES), community alternatives program (CAP), outward bound residential alternatives (OBRA), or coordinated community aids service alternatives (CASA) waivered service program.

(4) The department shall allow a community spouse applying for medically needy a spousal deduction equal to the one-person medically needy income level (MNIL) less the spouse's income when:

(a) The community spouse is living in the same household as the spouse; and

(b) The spouse is receiving home-based and community-based services.

(5) The department shall consider income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a congregate care facility (CCF), adult family home (AFH), adult residential rehabilitation center/adult residential treatment facility (ARRC/ARTF), or division of developmental disability-group home (DDD-GH) facility when:

- (a) Only one spouse enters the facility;
- (b) Both spouses enter the same facility but have separate rooms; or
- (c) Both spouses enter separate facilities.

(6) The department shall consider income and resources jointly when spouses are placed in a CCF, AFH, ARRC/ARTF, or DDD-GH facility and share a room.

(7) See Wac 388-408-0055 for rules on medical assistance units that include SSI-related persons.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-18-079, § 388-506-0620, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-506-0620, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-025.]

Chapter 388-510 WAC ALIEN MEDICAL ELIGIBILITY

WAC

388-510-1005 Definitions—Aliens.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-510-1020 Alien—Eligibility. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and RCW 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997, 98-15-066, § 388-510-1020, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-510-1020, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. Later promulgation, see WAC 388-424-0005.

388-510-1030 Alien—Deeming. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-510-1030, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. Later promulgation, see WAC 388-470-0060(6).

WAC 388-510-1005 Definitions—Aliens. "Legal immigrant" means an alien residing in the United States who is lawfully present with intent to remain. A legal immigrant includes, but is not limited to, an alien meeting PRUCOL criteria.

"Nonimmigrant" means an alien legally residing in the country but without an intent to remain permanently or who is not lawfully present.

"PRUCOL" means a person permanently residing under color of law.

"Qualified alien" means an alien:

- (1) Who is lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) (8 U.S.C. 12, Sec. 101 (a)(20));
- (2) Who is a refugee admitted to the United States under section 207 of such act;
- (3) Who is granted asylum under section 208 of Act;
- (4) Whose deportation is being withheld under section 243(h) of such act;
- (5) Who is paroled into the United States under section 212 (d)(5) of such Act for a period of at least one year;
- (6) Who is granted conditional entry under section 203 (a)(7) of such act as in effect prior to April 1, 1980;

(1999 Ed.)

(7) Who is a victim of domestic violence or an immigrant child that has been battered or subjected to extreme cruelty when:

(a) The immigrant petitions for legal status under section 204(a) of the INA or a petition for suspension of deportation under section 244(a) of the INA; and

(b) The person responsible for the battery no longer resides with the immigrant.

(8) Who is a Cuban or Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980; or

(9) Who is an Amerasian immigrant as defined in the Balanced Budget Agreement of 1997.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997, 98-15-066, § 388-510-1005, filed 7/13/98, effective 7/30/98.]

Chapter 388-511 WAC SSI-RELATED MEDICAL ELIGIBILITY

WAC

388-511-1105 SSI-related eligibility requirements.
388-511-1130 SSI-related income availability.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-511-1110 SSI-related resource standards. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1110, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-050.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0050 and 388-478-0080.

388-511-1115 SSI-related income standards. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1115, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-030.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0070 and 388-478-0055.

388-511-1140 SSI-related income exemptions. [Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160, 97-10-022, § 388-511-1140, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and State Plan Amendment Sup. 8a to Article 2.6-A page 6, 96-05-010 (Order 3943, #100295), § 388-511-1140, filed 2/9/96, effective 3/11/96. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605, 95-08-070 (Order 3845), § 388-511-1140, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1140, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-92-034 and 388-92-036.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0020 and 388-450-0040.

388-511-1150 SSI-related resource availability. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1150, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-040.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see chapter 388-470 WAC.

388-511-1160 SSI-related resource exemptions. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 42 CFR 435.601 and Section 4735 of the Federal Balanced Budget Act of 1997 (Public Law 105-33 (H.R. 2015)), 98-04-031, § 388-511-1160, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 74.08.090 and 74.04.050, 97-03-034, § 388-511-1160, filed 1/9/97,

388-511-1170	<p>effective 2/9/97. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605, 95-08-070 (Order 3845), § 388-511-1160, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1160, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-045.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-470-0040.</p> <p>SSI—State data exchange. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1170, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.</p>	<p>resource determination of the first moment of the first day of the month. The department shall determine changes in the amount of a client's countable resources during a month do not affect eligibility or ineligibility for that month. Refer to WAC 388-513-1395 for an institutionalized client.</p>
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WAC 388-511-1105 SSI-related eligibility requirements. (1) For the purposes of SSI-related medical assistance, the client shall be:

- (a) Sixty-five years of age or over; or
- (b) Blind with:

(i) Central visual acuity of 20/200 or less in the better eye with the use of a correcting lens; or

(ii) A limitation in the fields of vision so the widest diameter of the visual field subtends an angle no greater than twenty degrees; or

- (c) Disabled.

(i) Decisions on SSI-related disability are the responsibility of the medical assistance administration (MAA) and shall be subject to the authority of:

(A) Federal statutes and regulations codified at 42 U.S.C. Sec 1382c and 20 C.F.R. Parts 404 and 416, as amended; or

(B) Controlling federal court decisions which define the OASDI and SSI disability standard and determination process.

(ii) For MAA's purposes, "disabled" means unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which:

- (A) Can be expected to result in death; or

(B) Has lasted or can be expected to last for a continuous period of not less than twelve months.

(iii) In the case of a child seventeen years of age or younger, if the child suffers from any medically determinable physical or mental impairment of comparable severity.

(2) When a person has applied for Title II or Title XVI benefits and the SSA has denied the person's application solely because of a failure to meet Title II and Title XVI blindness or disability criteria, the SSA denial shall be binding on the department, unless the applicant's:

(a) SSA denial is under appeals in the reconsideration stage, the SSA's administrative hearing process, or the SSA's appeals council; or

(b) Medical condition has changed since the SSA denial was issued.

(3) The ineligible spouse, of an SSI beneficiary receiving a state supplement payment for the ineligible spouse, shall not be eligible for Medicaid as noninstitutional categorically needy. Such ineligible spouse may be eligible for noninstitutional medically needy.

(4) The client shall be resource eligible under WAC 388-478-0080 on the first day of the month to be eligible for any day or days of that month. The department shall make a

resource determination of the first moment of the first day of the month. The department shall determine changes in the amount of a client's countable resources during a month do not affect eligibility or ineligibility for that month. Refer to WAC 388-513-1395 for an institutionalized client.

(5) The department shall consider a client under 1619(b) of the Social Security Act as eligible for SSI.

(6) The department shall provide a resident of Washington requiring medical assistance outside the United States care according to WAC 388-501-0180.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-18-079, § 388-511-1105, filed 9/1/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 74.04.050, 97-03-036, § 388-511-1105, filed 1/9/97, effective 2/9/97. Statutory Authority: RCW 74.08.090, P.L. 100-383, AFDC Transmittal Memo, POMS 830.100, 830.115, 830.725 and 1130.605, 95-08-070 (Order 3845), § 388-511-1105, filed 4/5/95, effective 5/6/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1105, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-85-115 and 388-92-015.]

WAC 388-511-1130 SSI-related income availability. The department shall:

(1) Consider client checks received in advance of the month the checks are normally received as income in the month of normal receipt;

(2) Consider electronically transferred client funds available as income in the month of normal receipt, regardless of whether the banking institution posted the funds to the client's bank account before or after the month the funds are payable;

(3) Include as countable income the earned or unearned income amounts withheld due to garnishment under a court, administrative or agency order. See WAC 388-513-1380(4) for garnishment affecting an institutionalized client; and

(4) As a condition of eligibility, require a client to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which the client is entitled, unless the client can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veteran's compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation.

[Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160, 97-10-022, § 388-511-1130, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-511-1130, filed 5/3/94, effective 6/3/94. Formerly WAC 388-92-034 (part).]

Chapter 388-512 WAC
SSI-RELATED GRANDFATHERED RECIPIENTS

WAC

388-512-1210	Program description.
388-512-1215	General eligibility.
388-512-1220	Eligibility—Blindness.
388-512-1225	Permanently and totally disabled.
388-512-1230	Refusal to accept medical treatment.
388-512-1235	Review for disability or blindness.
388-512-1240	Computation of available income.
388-512-1245	Monthly maintenance standard—Own home.
388-512-1250	Monthly maintenance standard—Person in institution.
388-512-1255	Available income and nonexempt resources.
388-512-1260	Exempt resources.
388-512-1265	Nonexempt resources.
388-512-1275	Continuing certification.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-512-1280 Application following termination. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-512-1280, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-080.] Repealed by 98-04-004, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510.

WAC 388-512-1210 Program description. The department shall provide medical assistance within limitations set forth in these rules and regulations to a person who is a grandfathered client.

[Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-512-1210, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-010.]

WAC 388-512-1215 General eligibility. (1) There is no requirement of citizenship as a condition of eligibility for benefits under the medical care program.

(2) Residence; see WAC 388-504-0470.

(3) Medical need. The grandfathered client must have a medical need to remain eligible for medical assistance under Title XIX of the Social Security Act. Disability shall not constitute a medical need; treatment of disability does.

(4) The grandfathered client shall be:

- (a) Age sixty-five or older; or
- (b) Disabled as defined in WAC 388-512-1225; or
- (c) Blind as defined in WAC 388-512-1220 and not publicly soliciting alms by wearing, carrying or exhibiting signs denoting blindness, carrying receptacles for the reception of alms or doing the same by proxy or by begging. It shall be assumed that a person is not soliciting alms unless there is evidence to the contrary.

[Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-512-1215, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-015.]

WAC 388-512-1220 Eligibility—Blindness. "Blindness" is defined in terms of ophthalmic measurements as:

(1) Central visual acuity of 20/200 or less in the better eye with the best possible corrective glasses; or

(2) Contraction of the peripheral field of vision to within twenty degrees of the fixation point in all quadrants as determined by standard parametric testing; or

(3) Muscle function, measured in all parts of the motor field and charted upon 20 rectangles, 4 x 5 degrees in size, equal to 18/20 binocular or monocular.

[Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-512-1220, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-020.]

WAC 388-512-1225 Permanently and totally disabled. (1) In general, "permanently and totally disabled" means that a person has some permanent physical or mental impairment, disease or loss that substantially precludes a person from engaging in a useful occupation within a person's competence, such as holding a substantially gainful job or homemaking. The impairment may be physical or mental, organic or functional, and of such degree as to interfere with the person's faculties, such as senses, reasoning, or mobility. It may exist from birth, be acquired during the lifetime of the person, or result from an accident. It may be obvious, such as the loss of a limb, or it may be such that it can be revealed

only by medical examination. It may exist singly or in combination.

(2) The term "permanently disabled" refers to the existence of a physiological, anatomical, emotional and/or mental impairment verified by medical findings, which is of major importance, and is a condition not likely to improve, but will continue throughout the lifetime of the person. Any condition which is considered by the medical reviewer as not likely to respond to any known therapeutic procedure shall be deemed to be a permanent impairment. Any condition which is considered as likely to remain static or to become worse unless certain therapeutic measures are carried out shall be deemed to be permanent so long as treatment is unavailable, inadvisable, or the person refuses treatment and his decision is reasonable. See WAC 388-512-1230.

(a) A decision that an impairment is permanent can be made even though recovery from the impairment is possible. The discovery of new drugs or other advances in medical treatment is always a potential which may change a permanent situation; pending the actual physical improvement, the classification is proper. Therefore, the term "permanent" need not be everlasting or unchangeable, but is used in the sense of continuing indefinitely as distinct from temporary or transient.

(b) A physician's medical report must be used to establish the existence of an impairment and its permanency.

(3) The term "totally disabled" refers to a person's ability to perform those activities necessary to carry out specified responsibilities such as those necessary to employment or homemaking. Totality involves considerations in addition to those verified through the medical findings such as age, training, skills, and work experience, and the person's functioning in a person's particular situation in light of the impairment. Such social data will describe the person's education and work history, the activities required of the person at home or at work, living conditions, interests, capacity and limitations, and the extent to which the person has adjusted to the impairment.

(a) Job training may enable a permanently and totally disabled person to acquire a new skill in spite of the impairment. The person continues to be totally disabled during a reasonable period of training and until job competence is acquired.

(b) The social summary must show how the person reacts in social situations in order to illustrate that the disability substantially precludes the person from engaging in employment or homemaking in the foreseeable future. The social worker carries the major responsibility for providing the state office review team with the recorded objective social information bearing on the totality factor.

(4) The term "substantially precludes" relates to the extent to which a person's permanent impairment has left a person unable to engage in those activities necessary to carry on specified responsibilities such as employment and homemaking. If a person is able to perform such activities well enough and with sufficient regularity to receive substantial payment for such effort or to carry on homemaking responsibilities on a continuing basis, the person is not considered as precluded from engaging in "useful occupations" and cannot be found to be permanently and totally disabled.

(5) The term "**useful occupations**" means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value. The person whose impairment is so severe that it results in being unable to leave bed, leave home, or maintain body hygiene without the help of another person, and for whom the assumption would commonly be made that the person could not engage in any useful occupation, but in fact, through supreme effort the person does some work shall have ability to work evaluated in light of:

(a) The extent to which sympathy or compassion enters into the opportunity to engage in remunerative work. In other words, is the person able to do something because family, friends, or neighbors help more than is usual; for example, running errands, bringing materials, "engineering" the job, helping devise and create special tools, creating a market based more on sympathy than intrinsic value received, selling through church or other organization without charging the usual commission, etc.; and

(b) The extent to which the energy which must be discharged by the person is far beyond that which is ordinarily required for that activity. For example, does it take six or seven hours to do what most workers could do in an hour.

(c) If through careful consideration of such facts, in addition to the medical and social reports, it can be reasonably concluded that this person is doing more than can ordinarily be expected from persons with the impairments of similar severity, but activity is not substantially gainful, a finding of permanent and total disability may be reached.

(6) The term "**homemaking**" involves the ability to carry the home management and decision-making responsibilities and provide essential services within the home for at least one person in addition to oneself. This may be either a man or a woman. If homemaking is such that children are neglected or the other person receives practically no benefit from the homemaking efforts, these facts should be clearly shown in the social summary. If the homemaker must have the help of other persons to complete the essential household tasks, it may be shown that the person is not actually able to perform as a homemaker. The following activities are important to successful performance of the occupation of homemaking: Shopping for food and supplies; planning and preparing meals; washing dishes; cleaning house; making beds; washing and ironing clothes and, if the care of young children is within the homemaking responsibility, lifting and carrying infants; bathing and dressing young children; training and supervising children; accompanying children to community activities and to sources of medical care. A finding that a person is unable to perform the occupation of homemaking would require that the person is unable to perform a significant combination or grouping of these activities because of permanent impairment. When homemaking is the responsibility of the applicant, determination shall be made as to whether a permanent impairment prevents the client from totally meeting such responsibility.

(7) Special emotional problems.

(a) Alcoholism. For alcoholism to be considered permanently and totally disabling, at least one of the following criteria are required for approval of permanent and total disability:

(i) Evidence that a pathological or demonstrable organic damage has resulted from chronic alcoholism, such as neuritis or cirrhosis of the liver; or

(ii) Evidence that the alcoholism has reached the addiction state as shown by marked ethical deterioration, the obsessive character of the drinking, the approaching loss of alcohol tolerance, prolonged bouts, and a breakdown of the rationalization pattern; or

(iii) A history of several years of excessive drinking to the extent that it has adversely affected interpersonal relationships and social and economic functioning—loss of employment and inability to sustain employment because of excessive drinking.

(b) Personality inadequacy. Even though the medical report does not show a physical ailment which of itself is permanently disabling, a person may be found to be permanently and totally disabled if the medical or psychiatric report together with the social report supplemented with a psychological report, if indicated, shows an extended history of a combination of personality problems, character disorders or social inadequacies including unusual behavior, which prevents the person from making the adjustment required for an employable person or homemaker.

(i) This would include the person whose responses to the environment are habitually inadequate and who seems to have limited or no voluntary control over reactions. The symptoms of this emotionally unstable personality usually are demonstrated in antisocial or unconventional behavior; for example, drug addiction or alcoholism. The person does not get along with other people and may break many of society's rules. Most of these persons have had one difficulty after another since childhood with the typical lack of awareness and lack of remorse that is associated with this kind of behavior. The repetitive nature of their problems coupled with lack of motivation for change produces a person whose pattern provides a serious permanent impairment that can be totally disabling. Examples of this kind of personality might be:

(A) A patient returning from a mental hospital who is no longer psychotic but whose behavior would be unacceptable to a prospective employer or to family;

(B) The person who has never been able to hold a job due to a pattern of emotional instability, or other unusual behavior which shows that the person is unable, for an extended period, to substantially engage in any gainful occupation or homemaking;

(C) Drug addiction over an extended period of time.

(ii) In all cases of personality inadequacy, the reports specified in (b) of this subsection are required.

[Statutory Authority: RCW 74.08.090, 95-02-025 (Order 3816), § 388-512-1225, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-512-1225, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-025.]

WAC 388-512-1230 Refusal to accept medical treatment. (1) A disabled client who refuses without good cause to accept available medical treatment which can reasonably be expected to render the client able to work or do homemaking shall become ineligible.

(2) "**Available medical treatment**" shall mean medical, surgical or psychiatric therapy, or any combination of these treatments.

(3) "Reasonably be expected to render the client able to work or do homemaking" shall mean that, in the opinion of the state review team, the recommended medical, surgical, or psychiatric therapy is of such a nature and prognosis that, in the specific instance of the person involved, medical experience indicates that the recommended treatment will restore or substantially improve the person's ability to work for pay in a regular and predictable manner or to engage in homemaking.

(4) A client has good cause to refuse recommended medical treatment when, according to the best objective judgment of the state office review team, such refusal is based upon one or more of the following conditions:

(a) The person is genuinely fearful of undergoing recommended treatment. Such fear may appear to be unrealistic, or entirely emotional in origin, or irrational; however, fear exists in such a degree that treatment would be adversely affected and the doctor may therefore be dubious about undertaking to treat the person;

(b) The person could lose a faculty, or the remaining use of faculty the client now has, and refuses to accept the risk; or

(c) The person will not accept recommended medical treatment because of definitely stated religious scruples.

(5) The controlling principle in determining whether refusal was for or without good cause rests with the state office review team which will be guided by whether a reasonable, prudent person under similar circumstances would accept the recommended treatment. The determination will be made only after considering all social and medical evidence, including that furnished by the person, who will be provided with an opportunity to set forth in writing objective reasons for declining recommended treatment. A determination that a refusal to accept treatment without good cause is a decision which the client may appeal according to chapter 388-08 WAC.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1230, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-030.]

WAC 388-512-1235 Review for disability or blindness. (1) The grandfathered client's blindness or permanent and total disability shall be reviewed when a significant change has occurred.

(2) When a change in blindness occurs, an eye examination shall be secured from an ophthalmologist or optometrist and evaluated by the department's ophthalmological consultant. The ophthalmological consultant shall determine and certify whether legal blindness continues to exist.

(3) When a change in disability has occurred, a medical examination shall be secured. The medical reports shall be evaluated by the office of disability insurance to determine whether permanent and total disability continues to exist.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1235, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-035.]

WAC 388-512-1240 Computation of available income. (1) Income and net income shall be as defined in WAC 388-22-030. Total income of a beneficiary of supplementary security income is not considered an available resource except for institutionalized clients.

(1999 Ed.)

(2) To determine available income, deduct the following items from net income:

(a) Support payments being paid by the client under court order;

(b) Special nonmedical needs, such as payment to a wage earner's plan (specified by the court in a bankruptcy proceeding), or previously contracted major household repairs if failure to make payments would result in garnishment of wages or loss of employment;

(c) Tax rebates or special payments exempted by federal regulations and publicized by numbered memoranda from the state office.

(3) The exempt earned income shall be:

(a) For a former recipient of old age assistance or of disability assistance—the first twenty dollars plus one-half of the next sixty dollars;

(b) For a former recipient of aid to the blind—the first eighty-five dollars plus one-half of the amount over eighty-five dollars.

(4) Personal and nonpersonal work expense shall be deducted from earned income as follows:

(a) Mandatory deductions as required by law or as a condition of employment;

(b) Necessary cost of public transportation or eight cents a mile for private car to and from place of employment;

(c) Expenses of employment which are necessary to that employment such as tools, materials, union dues;

(d) Additional clothing costs. For a person doing clerical work, five dollars and seventy cents; for a person doing manual work, three dollars and sixty cents; for persons enrolled in remedial education or vocational training course, the actual cost of uniforms and/or special clothing;

(e) The cost of child care necessary to employment if not provided without cost or as departmental service. The actual expense shall be deducted but not to exceed standard in WAC 388-16-215.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1240, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-040.]

WAC 388-512-1245 Monthly maintenance standard—Own home. (1) The following monthly standards of available income for maintenance shall apply when determining financial eligibility:

FAMILY SIZE	STANDARD	FAMILY SIZE	STANDARD
1	\$195	10	\$591
2	\$237	11	\$635
3	\$282	12	\$679
4	\$327	13	\$723
5	\$371	14	\$768
6	\$415	15	\$812
7	\$459	16	\$856
8	\$503	17	\$900
9	\$547	18	\$944

(2) Forty-four dollars shall be added for each additional member.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1245, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-045.]

WAC 388-512-1250 Monthly maintenance standard—Person in institution. (1) The monthly standard for clothing and personal maintenance for a person in a skilled nursing facility or general hospital shall be twenty-five dollars.

(2) The monthly standards for clothing and personal maintenance for a person in an intermediate care facility shall be twenty-seven dollars and thirty cents.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1250, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-050.]

WAC 388-512-1255 Available income and nonexempt resources. (1) The person's available income determined according to WAC 388-512-1240 and nonexempt resources determined according to WAC 388-512-1260 and 388-512-1265 shall be allocated for the purposes and in the order specified in this section.

(2) Maintenance needs of the person living in his own home, or of legal dependents living in the family home if the individual is in an institution:

(a) Apply maintenance standards in WAC 388-512-1245; unless

(b) The legal dependents are applying for or receive public assistance, when the appropriate grant standards apply.

(3) Maintenance needs according to WAC 388-512-1250 for a person in an institution.

(4) Supplementary medical insurance premiums for an individual not in a nursing home who is eligible for medicare during the month of authorization and the month following if not withheld from the RSDI or RR benefit. See WAC 388-529-2960.

(5) Health and accident insurance premiums for policies continued in force from time of application.

(6) Costs not covered under this program for medical or remedial care as determined necessary by eligible providers according to WAC 388-87-005 (2)(a) and (h) initiated during a period of certification. See WAC 388-91-016 (1)(a).

(7) Participation in cost of care provided under this program except as provided in subsection (8) of this section; however, participation may not exceed:

(a) The excess regular income multiplied by six or the anticipated excess income that will be available within a six-month period, whichever is greater;

(b) The resources in excess of those listed in chapter 388-216 WAC. See WAC 388-512-1260;

(c) Additional cash resources that come into possession of the person during a period of certification.

(8) The twenty percent increase in Social Security benefits shall be considered exempt income when determining eligibility and participation for persons who in August 1972 received OAA, AFDC, AB or DA and also received RSDI benefits and who became ineligible for OAA, AFDC, AB or DA solely because of the twenty percent increase in Social Security benefits under Public Law 92-366.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1255, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-055.]

WAC 388-512-1260 Exempt resources. When determining the eligibility of the grandfathered client, the rules for exempt resources in chapter 388-216 WAC shall apply.

When separate property is a consideration, see WAC 388-216-2100.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1260, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-060.]

WAC 388-512-1265 Nonexempt resources. (1) All resources not specifically exempted in WAC 388-512-1260 shall be considered available for medical and nonmedical needs following priorities set forth in WAC 388-512-1245 through 388-512-1255. Value shall be assigned resources according to WAC 388-216-2800.

(2) The possession of a nonexempt resource affects eligibility for medical care. Except for nonexempt real property, the value assigned to such resources shall be the "fair market value." The "fair market value" of the resource is considered available toward the cost of medical care. Such amount is considered at the time of each review for as long as the resource is possessed by the client.

(3) When assigning value to nonexempt real property, follow this sequence:

(a) First consideration shall be given to the sale of nonexempt real property based on the "quick sale value."

(b) When sale is not possible, rental or lease must be considered with the income derived from such rental or lease being considered available to meet the cost of medical care.

(c) If the property cannot be sold, rented, or leased and if the client has used reasonable diligence in seeking a purchaser, renter, or lessee, then no resource value for this property shall be considered to exist for the purpose of determining eligibility. The property shall remain on the market for as long as the client is certified for medical care.

(4) An application for medical assistance from a person who refuses to dispose of his property or refuses to attempt to dispose of his property shall be denied.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1265, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-065.]

WAC 388-512-1275 Continuing certification. (1) A grandfathered client who continues to meet requirements under this chapter is eligible for medical assistance.

(2) When a grandfathered client does not meet the requirements under this chapter, the department shall:

(a) Terminate the client's medical assistance; and

(b) Redetermine the client's eligibility under chapter 388-511 WAC.

[Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510. 98-04-004, § 388-512-1275, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-512-1275, filed 5/3/94, effective 6/3/94. Formerly WAC 388-93-075.]

Chapter 388-513 WAC

CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

WAC

388-513-1300	Applicability of alternate living and institutional rules.
388-513-1305	Maintenance standard—Alternate living.
388-513-1310	Resource standard—Institutional.
388-513-1315	Eligibility determination—Institutional.
388-513-1320	Institutional status.
388-513-1330	Institutional—Available income.
388-513-1340	Institutional—Exempt income.
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388-513-1365	Transfer of assets.
388-513-1380	Institutional—Participation—Client share of monthly institutional payments.
388-513-1395	Institutional—Medically needy.
388-513-1396	Fraternal, religious, or benevolent nursing facility.

WAC 388-513-1300 Applicability of alternate living and institutional rules. (1) The department shall determine sections WAC 388-513-1305 and 388-513-1310 of this chapter apply to persons in alternate living situations.

(2) The department shall determine all sections other than WAC 388-513-1305 of this chapter apply to institutionalized persons as described under WAC 388-513-1365 (1)(f).

[Statutory Authority: RCW 74.08.090. 95-06-025 (Order 3834), § 388-513-1300, filed 2/22/95, effective 3/25/95.]

WAC 388-513-1305 Maintenance standard—Alternate living. (1) The department shall ensure the categorically needy monthly standard for an SSI, SSI-related, or GAU client living in an adult family home (AFH), adult residential treatment facility (ARTF), adult residential rehabilitation center (ARRC), congregate care facility (CCF), or division of developmental disabilities (DDD) group home is the department cost standard of the facility plus a specified CPI.

(2) The department shall determine the medically needy monthly standard for an SSI-related client living in an AFH, ARTF, ARRC, CCF, or DDD group home to be the private facility rate based on a thirty-one-day month plus a specified CPI.

(3) See WAC 388-15-555, 388-15-568, 388-250-1600, and 388-250-1650 for the definition of "**department cost standard**." The department shall ensure the monthly standard shall not exceed three hundred percent of the current SSI Federal Benefit Level.

(4) See chapter 388-511 WAC for computation of available income and resources for an SSI-related person.

(5) See chapter 388-219 WAC for computation of available income and resources for a GAU client.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1305, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-036 and 388-99-036.]

WAC 388-513-1310 Resource standard—Institutional. The department shall ensure the total value of resources allowed and not otherwise excluded not exceed the dollar amount in:

(1) Subsection (2)(a) of this section for a single person; or

(2) Subsection (2)(b) of this section for a couple. The resource limitation for a:

- (a) Single person shall be two thousand dollars; or
- (b) Couple shall be three thousand dollars.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1310, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-390.]

WAC 388-513-1315 Eligibility determination—Institutional. (1) A person is eligible for institutional care under the categorically needy program, if the person:

(a) Has achieved institutional status as described under WAC 388-513-1320; and

(1999 Ed.)

(b) Has gross nonexempt income:

(i) For an SSI-related person, no greater than three hundred percent of the SSI Federal Benefit Amount; or

(ii) For an AFDC or TANF-related person, no greater than the one-person program standard as described under WAC 388-505-0590, 388-508-0805, or 388-509-0960.

(c) Has resources which are:

(i) Not exempt under WAC 388-513-1360 and 388-513-1365, and

(ii) Less than the standards under WAC 388-513-1310 and 388-513-1395; and

(d) Is not subject to a period of ineligibility for transferring of resources under WAC 388-513-1365.

(2) A person is eligible for institutional care under the limited casualty program—medically needy, if the person meets the requirements in WAC 388-513-1395.

(3) For an AFDC- or TANF-related child under eighteen years of age residing or expected to reside in inpatient chemical dependency treatment or inpatient mental health treatment refer to WAC 388-506-0610 (1)(f).

(4) For other institutionalized persons twenty years of age or younger, the income and resources of the parents are not considered available unless the income and resources are actually contributed.

(5) A person is eligible for Medicaid who:

(a) Meets institutional status as a psychiatric facility resident; and

(b) Is twenty years of age or younger or is sixty-five years of age or older.

(6) A client's income and resources are allocated as described under WAC 388-513-1380.

(7) When both spouses are institutionalized, the department shall determine the eligibility of each spouse individually.

(8) A person's transfer between medical institutions is not a change in institutional status.

[Statutory Authority: RCW 74.04.050, 74.08.090 and 42 CFR 435.1005. 98-04-003, § 388-513-1315, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. 96-11-072 (Order 3980), § 388-513-1315, filed 5/10/96, effective 6/10/96. Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48. 95-19-007 (Order 3895), § 388-513-1315, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1315, filed 5/3/94, effective 6/3/94.]

WAC 388-513-1320 Institutional status. (1) The department shall find that a person has achieved institutional status when the person is residing or expected to reside in a Medicaid-certified medical facility for a period of at least:

(a) Ninety consecutive days for an AFDC-related child seventeen years of age or younger in residential mental health or chemical dependency/substance abuse treatment; or

(b) Thirty consecutive days for an SSI-related person and AFDC-related persons other than as described under subsection (1)(a) of this section.

(2) The department shall consider a person receiving waivered program services or hospice services to have achieved institutional status.

(3) The department shall make medical assistance available to an otherwise eligible person who has achieved institutional status as described under subsection (1) or (2) of this section.

(4) The department shall not deny Medicaid eligibility to a person in a nursing facility:

(a) On the grounds that the person did not establish residence in this state before entering the nursing facility; and

(b) When the person meets residency requirements described under chapter 388-505 WAC at the time the person applies for medical assistance.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 CFR 435.403 (j)(2), 97-15-025, § 388-513-1320, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090, 96-11-072 (Order 3980), § 388-513-1320, filed 5/10/96, effective 6/10/96; 94-10-065 (Order 3732), § 388-513-1320, filed 5/3/94, effective 6/3/94.]

WAC 388-513-1330 Institutional—Available income. (1) Income is defined under chapter 388-511 WAC for a SSI-related client and under WAC 388-22-030 for an AFDC-related client.

(2) The methodology and standards for determining and evaluating income are defined under chapter 388-513 WAC.

(3) The department shall consider the following income available to an institutionalized person when determining income eligibility unless the criteria in subsection (4) of this section is met:

(a) Income the institutionalized spouse receives in the institutionalized spouse's name;

(b) Income paid on the behalf of the institutionalized spouse, but received in the name of the institutionalized spouse's representative;

(c) One-half of the income the community and institutionalized spouses receive in both names; and

(d) Income from a trust as provided by the trust.

(4) The department shall consider income as available to an institutionalized person when:

(a) Both spouses are institutionalized; or

(b) An institutionalized person has a community spouse and income in excess of three hundred percent of the SSI federal benefit rate (FBR). For the determination of eligibility only:

(i) Use community property law in determining ownership of income for purposes of Medicaid eligibility;

(ii) Presume all income received after marriage by husband or wife to be community income;

(iii) Divide the total of the community income, by two assigning one-half of the total to each person; and

(iv) Consider if the community income received in the name of the nonapplying spouse exceeds the community income received in the name of the applying spouse, the applicant's interest in that excess shall be unavailable to the applicant.

(5) The department shall consider income the community spouse receives in the community spouse's name as unavailable to the institutionalized spouse.

(6) The department shall consider an agreement between spouses transferring or assigning rights to future income from one spouse to the other spouse, or to a trust for the benefit of the other spouse, to the extent the income is not derived from a resource which has been transferred, as invalid in determining eligibility for medical assistance or the limited casualty program for the medically needy.

(7) The department shall consider any agreement or trust transferring or assigning rights to future income, to the extent

the income is not derived from a resource which has been transferred, as invalid in determining eligibility for medical assistance or the limited casualty program for the medically needy.

(8) The department shall consider income produced by transferred or assigned resources as the separate income of the transferee.

(9) When an institutionalized spouse establishes the unavailability of income by a preponderance of evidence through a fair hearing, subsection (3) of this section shall not apply.

(10) See WAC 388-511-1130 for treatment of advance dated checks, and electronically transferred funds.

[Statutory Authority: RCW 74.08.090, 74.05.040 and 20 CFR 416.1110-1112, 1123 and 1160, 97-10-022, § 388-513-1330, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33, 95-02-028 (Order 3819), § 388-513-1330, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1330, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-335 and 388-95-340.]

WAC 388-513-1340 Institutional—Exempt income. The department shall consider a client's income exemptions as unavailable income when determining initial institutional eligibility or post-eligibility. The department shall exempt sequentially from income:

(1) Any public agency's refund of taxes paid on real property or on food;

(2) Supplemental security income (SSI) and state public assistance based on financial need;

(3) Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, or other necessary educational expenses at any educational institution;

(4) Child support received by a parent from an absent parent, for a minor child who is not institutionalized;

(5) Tax exempt payments received by Alaska natives under the Alaska Native Claims Act;

(6) Tax rebates or special payments excluded by other statutes;

(7) Compensation provided to volunteers in ACTION programs established by P.L. 93-113, The Domestic Volunteer Service Act of 1973;

(8) Veteran's Administration benefits designated for:

(a) The veteran's dependent;

(b) Unusual medical expense; and

(c) Aid and attendance and housebound allowance.

(9) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible client, for example, chore services;

(10) Funds received from the Agent Orange Settlement Fund or any other funds established to settle Agent Orange liability claims under P.L. 101-201;

(11) Payments to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act. Interest earned on conserved payment is not exempt;

(12) Payments under the Radiation Exposure Compensation Act received by the injured person, the surviving spouse, children, grandchildren, or grandparents;

(13) Payments under sections 500 through 506 of the Austrian General Social Insurance Act. The department shall

consider the earned interest from such payments as countable income;

(14) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(15) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry under P.L. 100-383;

(16) The amount of expenses directly related to a client's impairment that allows the permanently and totally disabled client to continue to work;

(17) The amount of blindness-related work expenses of a blind client;

(18) Interest earned on excluded burial funds and any appreciation in the value of an exempt burial arrangement which are left to accumulate and become part of the separately identified burial funds set aside on or after November 1, 1982;

(19) Earned income tax credit (EITC); and

(20) Victim's compensation.

[Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33, 95-02-028 (Order 3819), § 388-513-1340, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1340, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

WAC 388-513-1345 Institutional—Disregarded income. The department shall consider disregarded income as unavailable income when determining initial eligibility but shall consider the income available during post-eligibility. See WAC 388-513-1380 for post-eligibility treatment of income. The department shall disregard sequentially from income:

(1) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

(a) Twenty dollars per month if unearned; or

(b) Ten dollars per month if earned.

(2) The first twenty dollars per month of earned or unearned income. The department may not exclude income paid to a client on the basis of need and is totally or partially funded by the federal government or by a private agency.

(3) For an SSI-related person, the first sixty-five dollars per month of earned income not exempted under WAC 388-513-1340, plus one-half of the remainder.

(4) For an AFDC-related person, the first ninety dollars of earned income.

(5) Money voluntarily withheld from SSA Title II benefits by the Social Security Administration for the recovery of an SSI overpayment; and

(6) A fee charged by a guardian as reimbursement for provided services, when such guardianship services are a requirement for the client to receive payment of the income.

[Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33, 95-02-028 (Order 3819), § 388-513-1345, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1345, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

(1999 Ed.)

WAC 388-513-1350 Institutional—Available resources. This section describes those resources which are considered available to an institutionalized client.

(1) Resources are defined under chapter 388-511 WAC for an SSI-related client and under chapter 388-216 WAC for a TANF-related client.

(2) The methodology and standards for determining and evaluating resources are under WAC 388-513-1310, 388-513-1350, and 388-513-1360. Transfers of resources are evaluated under WAC 388-513-1365. Trusts are described under WAC 388-505-0595.

(3) "Continuously institutionalized" means a person is residing in a nursing facility or receiving home-based or community-based waivered services and the person has not had an absence or break in receiving services of thirty consecutive days.

(4) For a person whose most recent period of continuous institutionalization began on or before September 30, 1989:

(a) Available resources are one-half of the total value of nonexempt resources held in the:

(i) Names of both the institutionalized spouse and the community spouse; or

(ii) Name of the institutionalized spouse only.

(b) Unavailable resources are:

(i) The other half of the total value of nonexempt resources determined under subsection (3)(a) of this section;

(ii) Held solely in the name of the community spouse; or

(iii) Transferred between spouses as described under subsection (4)(b) of this section.

(5) For a person, whose most recent period of continuous institutionalization starts on or after October 1, 1989, available resources include all nonexempt resources in the name of either the community spouse or the institutionalized spouse except;

(a) The following resources are exempt when the institutionalized person has a community spouse:

(i) One vehicle without regard to use or value; and

(ii) Effective January 1, 1998, eighty thousand seven hundred sixty dollars; or

(b) An amount greater than the amount in subsection (4)(a)(ii) of this section if:

(i) Established by a fair hearing under chapter 388-08 WAC when the community spouse's resource allowance is inadequate to provide a minimum monthly maintenance needs allowance; or

(ii) Transferred to the community spouse by court order.

(6) Resources of the institutional spouse must be transferred to the community spouse or to another person for the sole benefit of the community spouse:

(i) Before the first regularly scheduled eligibility review; or

(ii) As soon as possible, taking into account the time necessary to obtain a court order for the support of the community spouse.

(7) The resources of the community spouse are:

(a) Unavailable to the institutionalized spouse:

(i) The month after the institutionalized spouse is determined eligible for institutional benefits; and

(ii) While the institutionalized spouse is continuously institutionalized.

(b) Available to the institutionalized spouse when the institutionalized spouse:

(i) Acquires resources which, when added to resources held by the institutionalized spouse, exceed the one-person resource maximum, if the most recent period of institutionalization began on or after October 1, 1989; or

(ii) Is not continuously institutionalized.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.575 and Section 1924 (42 USC 1396r-5). 98-11-033, § 388-513-1350, filed 5/14/98, effective 6/14/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. 97-09-112, § 388-513-1350, filed 4/23/97, effective 5/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1350, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1350, filed 2/8/95, effective 3/1/95. Statutory Authority: RCW 74.08.090. 94-23-129 (Order 3808), § 388-513-1350, filed 11/23/94, effective 12/24/94; 94-10-065 (Order 3732), § 388-513-1350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-337 and 388-95-340.]

WAC 388-513-1360 Resource exemptions. (1) In determining eligibility, the department shall exempt resources specified under WAC 388-511-1160.

(2) Effective July 1, 1996, the department shall exempt resources:

(a) For an aged, blind, or disabled person who has purchased a long-term care insurance policy approved by the Washington insurance commissioner under the Washington long-term care partnership program; and

(b) In an amount equal to the extent such policy has paid for licensed nursing facility and/or home- and community-based services covered under Medicaid.

(3) The department shall consider exempt resources described under subsection (2) of this section subject to estate recovery rules when the client has retained such resources.

(4) The department shall apply WAC 388-513-1365 for transfers of resources with the exception of resources exempted under subsection (2) of this section.

[Statutory Authority: RCW 74.08.090 and 48.85.020. 96-12-002 (Order 3982), § 388-513-1360, filed 5/22/96, effective 6/22/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1360, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-380.]

WAC 388-513-1365 Transfer of assets. (1) The terms in this section shall have the following definitions:

(a) "**Assets**" means all income and resources of a client and the client's spouse, including such income or resources the person is entitled to but does not receive because of action by:

(i) The client or the client's spouse;

(ii) A person, court or administrative body, with legal authority to act in place of or on behalf of the client or the client's spouse; or

(iii) A person, court or administrative body, acting at the direction or upon the request of the client or the client's spouse.

(b) "**Community spouse**" means the person married to an institutionalized client.

(c) "**Fair market value (FMV)**" means the price the asset may reasonably sell for on the open market at the time of transfer or assignment. A transfer of assets for love and affection is not considered a transfer for FMV.

(d) "**Institutional services**" means a level of care provided in a nursing facility, equivalent nursing facility in a medical institution, or in a home-based or community-based program under WAC 388-515-1505 or 388-515-1510.

(e) "**Institutional spouse**" means a client who meets the requirements of subsection (1)(f) of this section and is married to a spouse who is not:

(i) In a medical institution;

(ii) In a nursing facility; or

(iii) Receiving home-based or community-based services under WAC 388-515-1505 or 388-515-1510.

(f) "**Institutionalized client**" means a person who is:

(i) An inpatient in a nursing facility;

(ii) An inpatient in a medical institution where the payment is made for a level of care provided in a nursing facility; or

(iii) In need of the level of care provided in a nursing facility or medical institution, but receiving home-based or community-based services under WAC 388-515-1505 or 388-515-1510; and

(iv) Expected to be in a nursing facility, in a medical institution, or receiving home-based or community-based services under WAC 388-515-1505 or 388-515-1510 for thirty consecutive days or more.

(g) "**Transfer**" means any act or omission to act, by a client or a nonapplying joint tenant, whereby title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person, including but not limited to:

(i) Delivery of personal property;

(ii) Bills of sale, deeds, mortgages, and pledges; or

(iii) Any other instrument conveying or relinquishing an interest in property.

(h) "**Uncompensated value**" means the FMV of an asset at the time of transfer minus the value of compensation the person receives in exchange for the resource.

(i) "**Undue hardship**" means the client's inability to meet shelter, food, clothing, and health needs.

(j) "**Value of compensation received**" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(i) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable agreement whereby the eligible client shall transfer the resource; and

(ii) The payment or assumption of a legal debt the client owes in exchange for the resource.

(2) The department shall not impose any penalty for the transfer of any exempt asset for less than FMV except as specified under subsection (11) of this section when the client transfers the client's home.

(3) The department shall determine whether the client or the client's spouse transferred an asset within a look-back period of the following duration:

(a) Thirty months when determining eligibility for services received:

(i) On or before September 30, 1993; or

(ii) On or after October 1, 1993, with respect to transfers of assets on or before August 10, 1993;

(b) Thirty-six months when determining eligibility for services on or after October 1, 1993, with respect to transfers of assets on or after August 11, 1993; or

(c) Sixty months when determining eligibility for services received on or after October 1, 1993, and all or part of the transferred assets are placed in a trust established on or after August 11, 1993, and all or part of the assets are deemed transferred as described under WAC 388-505-0595.

(4) The department shall consider the look-back period as the number of months described under subsection (3) of this section but not including any month before August, 1993 in the case of subsections (3)(b) and (3)(c) of this section, before the first day of the month the client:

(a) Becomes an institutionalized person, if the client is eligible for medical assistance on that date; or

(b) Applies for institutional care when the client is not eligible for medical assistance as of the date the client initially became institutionalized.

(5) The department shall calculate a period of ineligibility for nursing facility services, equivalent nursing facility services in a medical institution, and services described under WAC 388-515-1505 and 388-515-1510, for the institutionalized client when the client or the client's spouse transfers an asset for less than FMV during or after the look-back periods as described under subsections (3) and (4) of this section.

(6) When the client or the client's spouse has transferred assets, the department shall establish a period of ineligibility:

(a) Under subsection (7) of this section for assets transferred on or before August 10, 1993;

(b) Under subsection (8) of this section for assets transferred on or after August 11, 1993 and on or before February 28, 1997; and

(c) Under subsection (9) of this section for assets transferred on or after March 1, 1997.

(7) With respect to transfers of assets on or before August 10, 1993, and in any month within the applicable look-back period, the department shall establish a period of ineligibility which:

(a) Begins the first day of the month in which the assets were transferred;

(b) Is the lesser of:

(i) Thirty months; or

(ii) The number of whole months found by dividing the total uncompensated value of the assets transferred in the month by the state-wide average monthly cost of nursing facility services to a private patient at the time of the application; and

(c) Runs concurrently when transfers of assets have been made in multiple months during the look-back period.

(8) With respect to transfers of assets on or after August 11, 1993 and on or before February 28, 1997, and in any month within the applicable look-back period occurring on or after August 11, 1993, the department shall establish a period of ineligibility as follows:

(a) For such transfers during the look-back period:

(i) The period of ineligibility shall begin on the first day of the month in which such assets were transferred; and

(ii) Equal the number of whole months found by dividing the total, cumulative uncompensated value of all such assets transferred during the look-back period by the state-wide

average monthly cost of nursing facility services to a private patient at the time of application.

(b) For such transfers of assets made while receiving medical assistance as an institutionalized client, or for such transfers made during a period of ineligibility established under this section:

(i) The period of ineligibility shall begin on the first day of the month in which such assets were transferred, or after the expiration of all other periods of ineligibility established under this section, whichever is later; and

(ii) Equal the number of whole months found by dividing the total, uncompensated value of such transferred assets by the state-wide average monthly cost of nursing facility services to a private patient at the time of application.

(9) With respect to transfers of assets on or after March 1, 1997 and in any month within the applicable look-back period occurring on or after August 11, 1993, the department shall:

(a) For a single transfer or multiple transfers within a single month during the look-back period:

(i) Add the value of all transferred assets;

(ii) Divide the total value of all transferred assets by the statewide average monthly cost of nursing facility services to a private patient at the time of application; and

(iii) Establish a period of ineligibility:

(A) Equal to the number of whole months as established under subsection (9)(a)(i) and (ii) of this section; and

(B) Which begins on the first day of the month of transfer.

(b) For multiple transfers during multiple months during the look-back period:

(i) Treat assets transferred in each month as a separate event with its own period of ineligibility;

(ii) Divide the total value of assets transferred in a month by the statewide average monthly cost of nursing facility services to a private patient at the time of application; and

(iii) Establish multiple periods of ineligibility:

(A) Equal to the number of whole months as established under subsection (9)(b)(i) and (ii) of this section; and

(B) Which begin the latter of:

(I) The first day of the month of each transfer; or

(II) The first day of the month following the expiration of a previously computed period of ineligibility.

(10) The department shall not consider gifts or donations totaling one thousand dollars or under in any month as transfers of assets under subsections (7), (8), or (9) of this section.

(11) The department shall not find the institutionalized client ineligible for institutionalized services when the transferred asset was a home and the home was transferred to the client's:

(a) Spouse; or

(b) Child who is:

(i) Blind, or permanently and totally disabled; or

(ii) Twenty years of age or under.

(c) Sibling who has:

(i) Equity in the home; and

(ii) Lived in the home for at least one year immediately before the client became institutionalized.

(d) Child, other than described under subsection (11)(b) of this section who:

(i) Lived in the home for two years or more immediately before the client became institutionalized; and

(ii) Provided care to the client to permit the client to remain at home.

(12) The department shall not find the institutionalized client ineligible for institutionalized services if the asset other than the home was transferred:

(a) To the client's spouse or to another person for the sole benefit of the client's spouse;

(b) From the client's spouse to another person for the sole benefit of the client's spouse;

(c) To the client's blind or permanently and totally disabled child, or to a trust established solely for the benefit of such child; or

(d) To a trust established solely for the benefit of a person sixty-four years of age or younger who is disabled according to SSI criteria.

(13) The department shall only consider a transfer of assets or trust established under subsection (12) of this section for the sole benefit of the named person when:

(a) The transfer or trust document provides for the expenditure of funds for the benefit of the person; and

(b) Such expenditures must be on a basis that is actuarially sound, based on the life expectancy of the person.

(14) The department shall consider a transfer of asset or trust established under subsection (12) of this section which does not meet the criteria found under subsection (13) of this section under subsection (7), (8), or (9) of this section.

(15) The department shall not find a person ineligible under this section when the client can satisfactorily show the department that:

(a) The client intended to transfer the asset at FMV or other valuable consideration;

(b) The client transferred the asset exclusively for a purpose other than to qualify for medical assistance;

(c) All assets transferred by the client for less than FMV have been returned to the client; or

(d) The client's denial of eligibility would cause an undue hardship.

(16) The department shall not impose a period of ineligibility on a client unless the client is subject to a period of ineligibility, as calculated under this section, with respect to any month for which eligibility for institutional services is sought.

(17) A client or the spouse of such a client, the department determines ineligible under this section, may request a hearing to appeal the determination of ineligibility. The procedure for the hearing is described under chapter 388-08 WAC.

(18) The department shall:

(a) Exempt cash received from the sale, transfer, or exchange of an asset to the extent that the cash is used for an exempt asset within the same month, except as specified under WAC 388-511-1160; and

(b) Consider any cash remaining as an available asset.

(19) When the transfer of an asset has resulted in a period of ineligibility for one spouse, the department shall not impose a period of ineligibility for the other spouse for the transfer of the same asset.

(20) The department shall disregard the transfer of assets to a family member when:

(a) The family member has received the assets for providing care to the client which keeps the client out of a nursing facility;

(b) The client and the family member initiated a written agreement at the time the care began; and

(c) The written agreement states:

(i) The fair market value of the care; and

(ii) That the care is to be paid from the assets of the client.

(21) When the fair market value of the care described under subsection (20) of this section is less than the value of the transferred asset, the department shall consider the difference as the transfer of an asset without adequate consideration.

(22) The department shall consider the transfer of an asset in exchange for care given by a family member without a written agreement as described under subsection (20) of this section as a transfer of an asset without adequate consideration.

(23) When the transfer of an asset includes the right to receive a stream of income received on a regular basis which has been transferred to a spouse, to the extent the income is not derived from a transferred resource, the department shall consider such a transfer under WAC 388-513-1330(6).

(24) When the transfer of an asset includes the right to receive a stream of income received on a regular basis which has been transferred to a person other than a spouse, to the extent the income is not derived from a transferred resource, the department shall:

(a) Add the total amount of income expected to be transferred during the person's lifetime, based on an actuarial projection of the person's life expectancy to the extent the income is not derived from a transferred resource; and

(b) Divide the total value of the transferred income by the statewide average monthly cost of nursing facility services to a private patient at the time of application; and

(c) Establish a period of ineligibility:

(i) Equal to the number of whole months as established under subsection (24)(a) and (b) of this section; and

(ii) Which begins the latter of:

(A) The first day of the month the person transferred the income stream; or

(B) The first day of the month following the expiration of a previously computed period of ineligibility.

[Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.585 and § 17 of the Social Security Act. 97-05-040, § 388-513-1365, filed 2/14/97, effective 3/17/97. Statutory Authority: RCW 74.08.090. 95-02-027 (Order 3818), § 388-513-1365, filed 12/28/94, effective 1/28/95; 94-10-065 (Order 3732), § 388-513-1365, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-395.]

WAC 388-513-1380 Institutional—Participation—Client share of monthly institutional payments. This section describes the allocations which can be deducted from the institutional client's income and excess resources in order to determine the amount available for the client's participation in the cost of care.

(1) The client's excess resources are available to meet the cost of care after the following deductions in this order:

(a) Health insurance and Medicare premiums, deductions, and co-insurance not paid by a third party; and

(b) Noncovered medical bills which are the liability of the client and not paid by a third party.

(2) The allocations used to reduce excess resources under subsection (1) of this section cannot be used to reduce income under subsection (3) of this section.

(3) The client's nonexempt income is available to meet the cost of care after the following deductions in this order:

(a) Deductions described in subsection (3)(a) may not total more than the one-person medically needy income level (MNIL):

(i) A personal needs allowance (PNA) as follows:

(A) One hundred sixty dollars for a veteran living in a Medicaid-certified state veteran's home nursing facility;

(B) Ninety dollars for a single veteran, or widow or widower of a veteran receiving an improved veteran's pension; or

(C) Forty-one dollars and sixty-two cents for all other clients in a medical facility.

(ii) Federal, state, or local income taxes:

(A) Mandatorily withheld from earned or unearned income for income tax purposes before receipt by the client; or

(B) Not covered by withholding, but are owed or have been paid by the client.

(iii) Wages for a client who:

(A) Is SSI-related; and

(B) Receives the wages as part of a department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction employment expenses are not deducted.

(iv) Guardianship fees and administrative costs including any attorney fees paid by the guardian, after June 15, 1998, only as allowed by chapter 388-79 WAC.

(b) A monthly needs allowance for the community spouse not to exceed, effective January 1, 1998, two thousand nineteen dollars, unless specified in subsection (5) of this section. The monthly needs allowance is:

(i) An amount added to the community spouse's gross income to provide a total of one thousand three hundred fifty-eight dollars;

(ii) Excess shelter expenses as specified under subsection (4) of this section; and

(iii) Allowed only to the extent the client's income is made available to the community spouse.

(c) A monthly maintenance needs amount for each dependent or minor child, dependent parent or dependent sibling:

(i) Residing with the community spouse, equal to one-third of the amount that one thousand three hundred fifty-eight dollars exceeds the family member's income. Child support received from an absent parent is the child's income.

(ii) Not residing with the community spouse, equal to the MNIL for the number of family members in the home less the income of the family members.

(d) Incurred medical expenses, not subject to third-party payment, which are the current liability of the client including:

(i) Health insurance premiums, deductions, and coinsurance amounts; and

(ii) Necessary medical care recognized under state law, but not covered under Medicaid.

(e) Maintenance of the home of a single person or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client is likely to return to the home within the six-month period; and

(iv) When social service staff documents initial need for the income exemption and reviews the person's circumstances after ninety days.

(4) For the purposes of this section, "excess shelter expenses" equal the actual expenses under subsection (4)(a) of this section less the standard shelter allocation under subsection (4)(b) of this section:

(a) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:

(i) Rent;

(ii) Mortgage;

(iii) Taxes and insurance;

(iv) Any maintenance care for a condominium or cooperative; and

(v) The food stamp standard utility allowance, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(b) The standard shelter allocation is four hundred eight dollars, effective April 1, 1997.

(5) The amount the institutional spouse may allocate to the community spouse may be greater than the amount in subsection (3)(b) of this section only when:

(a) A court enters an order against the institutionalized client for the support of the community spouse; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(6) SSI clients shall continue to receive total payment under 1611 (b)(1) of the Social Security Act for the first three full calendar months of institutionalization in a public or Medicaid-approved medical institution or facility when the:

(a) Stay in the institution or facility is not expected to exceed three months; and

(b) The client plans to return to former living arrangements.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 43.20B.460, 11.92.180, and Section 1924 (42 USC 396r-5). 98-08-077, § 388-513-1380, filed 3/31/98, effective 4/1/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m). 97-16-008, § 388-513-1380, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1380, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. 95-11-045 (Order 3848), § 388-513-1380, filed 5/10/95, effective 6/10/95. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1380, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1380, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-360.]

WAC 388-513-1395 Institutional—Medically needy.

(1) The department shall consider a person institutionalized when the person resides in or is expected to reside in a medical facility for thirty consecutive days or more.

(a) The department shall determine:

(i) An SSI/SSP-related person in a medical facility as medically needy when the person's gross income exceeds three hundred percent of the SSI benefit amount;

(ii) An AFDC-related child in a medical facility as medically needy if countable income exceeds the one-person AFDC grant standard; and

(iii) An AFDC-related adult as ineligible.

(b) The department shall determine a client ineligible for the medically needy program when the countable income is more than the private nursing facility rate plus verifiable recurring medical expenses.

(c) The department shall determine countable income of a medically needy client residing in a nursing facility by deducting the following amounts from gross income:

(i) Amounts that would be deducted in determining eligibility for AFDC or SSI/SSP; and

(ii) Previously incurred medical expenses not subject to third-party payment and which are the current liability of the client.

(d) The department shall determine a client eligible for nursing facility care when the client's countable income and the amount of resources in excess of the amount in WAC 388-513-1310 are less than the department's contracted rate plus verifiable recurring medical expenses. These clients shall:

(i) Participate in the cost of nursing facility care per WAC 388-513-1380 for post-eligibility allocation of income and post-eligibility allocation of resources; and

(ii) Be certified for a three-, six-, or twelve-month period as described under WAC 388-519-1905.

(e) The department shall determine a client eligible for nursing facility care when the client's countable income and the amount of resources in excess of the amount in WAC 388-513-1310 are:

(i) Less than the private nursing facility rate plus recurring medical expenses; but

(ii) More than the department's contracted rate.

(f) The client shall:

(i) Participate in the cost of nursing facility care. See WAC 388-513-1380 for post-eligibility allocation of income;

(ii) Spenddown all income remaining after allocating income to the department's contracted rate to be eligible for nonnursing facility medical care. The department shall only certify medical assistance for noninstitutional eligibility after spenddown has been met; and

(iii) Choose a certification period of three or six months for nursing facility care. The department shall determine spenddown of a person's nonnursing facility medical expenses be on a three-month or six-month basis.

(g) For the effect of a social absence from an institutional living arrangement, see WAC 388-88-115.

(h) The department shall not change a client's institutional status when the client is transferred between institutions.

(2) The department shall use other SSI financial criteria for consideration of resources as defined in WAC 388-513-1310 and 388-513-1360.

[Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-513-1395, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. 95-24-017 (Order 3921, #100267), § 388-513-1395, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1395, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-400.]

WAC 388-513-1396 Fraternal, religious, or benevolent nursing facility. (1) The department shall find an otherwise eligible client, residing in a nursing facility operated by a fraternal, religious, or benevolent organization:

(a) Eligible for medical care when the:

(i) Facility is licensed as a nursing facility; and

(ii) Contract between the client and the nursing facility excludes free or prepaid institutional and/or medical care for life; or

(iii) Nursing facility is unable to fulfill the terms of the contract and has:

(A) Voided the contract; and

(B) Refunded to the client any existing assets of the client;

(b) Ineligible for institutional and/or medical care when a contract between the client and the facility includes free or prepaid institutional and/or medical care for life.

(2) The department shall consider available to the client all assets of a fraternal, religious, or benevolent organization when the client:

(a) Signs a contract with the organization that includes free or prepaid institutional and/or medical care for the life of the client; and

(b) Surrenders income and/or resources to the organization in exchange for such care.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-513-1396, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-310.]

Chapter 388-515 WAC

ALTERNATE LIVING—INSTITUTIONAL MEDICAL WAC

388-515-1505	Community options program entry system (COPES).
388-515-1510	Community alternatives program (CAP) and outward bound residential alternatives (OBRA).
388-515-1530	Coordinated community AIDS services alternatives (CASA) program.

WAC 388-515-1505 Community options program entry system (COPES). (1) The department shall determine a person eligible for COPES when a person is eighteen years of age or over and:

(a) Meets the categorically needy eligibility requirements for an SSI-related institutionalized person. For the purposes of COPES, a person is considered institutionalized as of the date all eligibility criteria, except institutionalized status, is met;

(b) Requires the level of care provided in a nursing facility;

(c) Has a department-approved plan of care that meets the eligibility requirements for COPES personal care as described under WAC 388-15-610; and

(d) Is able and chooses to reside at home with community support services, in a:

- (i) Congregate care facility (CCF);
- (ii) Licensed adult family home (AFH); or
- (iii) Licensed boarding home (LBH).

(e) Is institutionalized, or the department determines is likely to be institutionalized within the next thirty days in the absence of waivered services under WAC 388-15-615.

(2) The department shall exempt SSI income from participation in the cost of COPES care.

(3) The department shall allocate available income of the SSI-related COPES client as described under WAC 388-513-1380 (1), (2), (3), (4), (d), (e), (f), (g), and (h), (5), and (6). The client shall retain for maintenance needs an amount equal to:

(a) For a single person or a married person not living with a community spouse, one hundred percent of the one-person Federal Poverty Level (FPL);

(b) For a married couple who are both receiving COPES, one hundred percent of the one-person FPL for each person; or

(c) For a married person living with a community spouse, the one-person MNIL.

(4) The SSI-related client residing in a CCF, AFH, or LBH shall:

(a) Retain from a maintenance needs amount, a personal needs allowance of fifty dollars; and

(b) Pay the remaining maintenance needs amount to the facility for the cost of board and room.

(5) The department shall include the remaining income after allocations as the participation amount for COPES services as described under WAC 388-15-620.

[Statutory Authority: RCW 74.08.090, 96-14-058 (Order 100346), § 388-515-1505, filed 6/27/96, effective 7/28/96; 95-20-030 (Order 3899), § 388-515-1505, filed 9/27/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-515-1505, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-200.]

WAC 388-515-1510 Community alternatives program (CAP) and outward bound residential alternatives (OBRA). (1) The department shall determine an eligible person for CAP is a person:

(a) Meeting the requirements and eligible for division of developmental disabilities (DDD) services and disabled according to SSI rules;

(b) Meeting the categorically needy eligibility requirements for an SSI-related institutionalized person. For the purposes of CAP and OBRA, a person is considered institutionalized as of the date all eligibility criteria, except institutionalized status is met;

(c) The department assesses as requiring the level of care provided in an intermediate care facility for the mentally retarded (IMR);

(d) For whom the department approves an individual plan of care describing the provided community support services; and

(e) Able and choosing to reside in the community with community support services according to the plan of care.

(2) The department shall determine an eligible person for the OBRA home-based and community-based services program is a person:

(1999 Ed.)

(a) Meeting the CAP eligibility standards in WAC 388-515-1510(1); and

(b) Residing in a Medicaid nursing facility at the time of application for OBRA services.

(3) The department shall not require participation in the cost of CAP or OBRA services by a person:

(a) Receiving SSI; or

(b) Remaining eligible for SSI under 1619(b) of the Social Security Act, but not receiving a cash grant.

(4) The department shall allocate available total income, including amounts disregarded in determining eligibility, of a SSI-related CAP or OBRA client as follows:

(a) For a client living in the client's residence, including a client receiving intensive tenant support services, the department shall use an amount equal to a maximum of three hundred percent of the SSI Federal Benefit Rate for one person for the client's maintenance needs;

(b) For a client residing in a state-contracted or state-operated group home, adult family home, or congregate care facility, the department shall use the following amounts for the client's maintenance needs:

(i) A specified personal needs allowance, as described under WAC 388-250-1600 and 388-250-1650;

(ii) An amount equal to the monthly room and board cost for the facility where the client resides;

(iii) The first twenty dollars per month of earned or unearned income; and

(iv) The first sixty-five dollars plus one-half of the remaining earned income not previously excluded.

(c) For a client described in (b) of this subsection, the maximum amount allowed for any client's individual maintenance needs shall not exceed three hundred percent of the SSI Federal Benefit Rate. The department shall not allow a client an individual maintenance needs deduction of less than the SSI payment standard;

(d) For a client with a spouse at home who is not receiving CAP or OBRA services, the department shall allocate an amount for the spouse's maintenance needs as computed under WAC 388-513-1380 (4)(e);

(e) For a client with a dependent relative living with the spouse not receiving CAP or OBRA services, the department shall designate an amount for the relative's maintenance needs as computed in WAC 388-513-1380 (4)(f);

(f) The department shall use amounts for incurred medical expenses not subject to third-party payment, including:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical care recognized under state law but not covered under Medicaid.

(g) The department shall ensure income remaining after deductions in (a), (b), (c), (d), (e), and (f) of this subsection will be the participation amount for CAP or OBRA services.

[Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-515-1510, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-210.]

WAC 388-515-1530 Coordinated community AIDS services alternatives (CASA) program. (1) The department shall determine that a person is eligible for CASA if the person:

[Title 388 WAC—p. 643]

(a) Meets the categorically needy eligibility requirements for an SSI-related institutionalized person. For the purposes of CASA, the department shall consider a person institutionalized the date the person meets eligibility criteria, except institutionalized status;

(b) Has a diagnosis of:

(i) Acquired immune deficiency syndrome or disabling Class IV human immunodeficiency virus disease; or

(ii) P2 HIV/AIDS diagnosis, if fourteen years of age or under.

(c) Is determined medically at risk of need for the level of hospital-provided care;

(d) Is certified by the person's physician or nurse practitioner as in the terminal state of life;

(e) Agrees to receive services in the person's own home, a licensed congregate care facility, or adult family home;

(f) Has a plan of care approved by the department and the department of health; and

(g) Does not have private insurance, including COBRA extensions, that covers inpatient hospital care.

(2) The department shall not require participation in the cost of CASA services by a person:

(a) Receiving SSI; or

(b) Remaining eligible for SSI under 1619(b) of the Social Security Act, but not receiving a cash grant.

(3) The department shall allocate available total income, including amounts disregarded in determining eligibility of a SSI-related CASA client residing at home, as follows:

(a) The client retains as maintenance needs an amount equal to the special income level (SIL) for one person; and

(b) As described under WAC 388-513-1380 (1), (2), (3), (4)(b), (c), (d), (e), (f), (g), and (h), (5), and (6).

(4) The department shall allocate available total income, including amounts disregarded in determining eligibility of a CASA client residing in an adult family home or congregate care facility, as follows:

(a) The client shall retain a specified personal needs allowance as described under WAC 388-250-1600 or 388-250-1650;

(b) As described under WAC 388-513-1380 (1), (2), (3), (4)(c), (d), (e), (f), and (g), (5), and (6); and

(c) Pay remaining income up to the SIL to the facility for the cost of board and room.

(5) The SSI-related CASA client's income remaining after deductions in subsection (3) or (4) of this section shall be the participation amount for CASA services.

(6) When the department has determined that the client has financial participation under subsection (5) of this section, the department shall require the client to meet the participation obligation to remain eligible.

[Statutory Authority: RCW 74.08.090, 95-18-001 (Order 3882), § 388-515-1530, filed 8/23/95, effective 9/23/95; 94-10-065 (Order 3732), § 388-515-1530, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-220.]

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-517-1710	Medicare cost-sharing programs. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997, 98-11-073, § 388-517-1710, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090, 95-14-046 (Order 3863), § 388-517-1710, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-060.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300.
388-517-1715	Qualified Medicare beneficiary (QMB) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997, 98-11-073, § 388-517-1715, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090, 95-14-046 (Order 3863), § 388-517-1715, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1715, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-140 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0085(1) and 388-517-0500(6).
388-517-1720	Qualified Medicare beneficiaries—Income and resources. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m), 97-16-008, § 388-517-1720, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090, 96-15-029, § 388-517-1720, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-517-1720, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1720, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-140 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.
388-517-1730	Special low-income Medicare beneficiaries (SLMB) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997, 98-11-073, § 388-517-1730, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090, 95-14-046 (Order 3863), § 388-517-1730, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1730, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-150 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-478-0085(2) and 388-517-0300(4).
388-517-1740	Special low-income Medicare beneficiaries (SLMB)—Income and resources. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m), 97-16-008, § 388-517-1740, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090, 96-15-029, § 388-517-1740, filed 7/10/96, effective 7/10/96; 95-23-030 (Order 3917, #100251), § 388-517-1740, filed 11/8/95, effective 12/9/95; 95-11-056 (Order 3848A), § 388-517-1740, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1740, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-150 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.
388-517-1750	Qualified disabled working individuals (QDWI) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997, 98-11-073, § 388-517-1750, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.08.090, 95-14-046 (Order 3863), § 388-517-1750, filed 6/28/95, effective 7/29/95; 94-10-065 (Order 3732), § 388-517-1750, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-160 (part).] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055,

Chapter 388-517 WAC MEDICARE-RELATED MEDICAL ELIGIBILITY

WAC

388-517-0300 Medicare cost-sharing programs.

388-517-1760	74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300(6) and 388-478-0085. Qualified disabled working individuals (QDWI) income and resources. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m). 97-16-008, § 388-517-1760, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090, 96-15-029, § 388-517-1760, filed 7/10/96, effective 7/10/96; 95-11-056 (Order 3848A), § 388-517-1760, filed 5/11/95, effective 6/11/95; 94-10-065 (Order 3732), § 388-517-1760, filed 5/3/94, effective 6/3/94. Formerly WAC 388-82-160 (part).] Repealed by 98-11-073, filed 5/19/98, effective 6/19/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997.
388-517-1770	Qualified individuals (QI) program. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and H.R. 2015, Sec. 4732, The Balanced Budget Act of 1997. 98-11-073, § 388-517-1770, filed 5/19/98, effective 6/19/98.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0300(7) and 388-478-0085(5).

WAC 388-517-0300 Medicare cost-sharing programs. (1) Clients eligible for the following programs receive benefits which help pay their Medicare coverage out-of-pocket costs:

- (a) The qualified medicare beneficiary (QMB); and
- (b) The special low-income medicare beneficiary (SLMB) and the expanded special low income Medicare beneficiary (ESLMB); and
- (c) The Medicare buy-in program; and
- (d) The qualified disabled working individual (QDWI); and
- (e) The qualified individual (QI).

(2) To be eligible for any of these programs, clients must not have countable resources which exceed the resource standard in WAC 388-478-0085(6).

(3) Clients eligible for or receiving Medicare Part A and meeting the department's income standards have their Medicare Part A and Part B premiums, coinsurance, and deductibles paid for them under the QMB program. A person is income-eligible for QMB:

- (a) When their countable income does not exceed the standard in WAC 388-478-0085(1); or
- (b) When they meet the requirements of subsection (a) if their annual Social Security cost-of-living increase is not counted as income until April 1 of each year.

(4) Clients eligible for or receiving Medicare Part A benefits and meeting the department's income standards have their Part B Medicare premium paid for them under the SLMB or ESLMB program. In determining eligibility for SLMB or ESLMB, the annual Social Security cost-of-living increase is not counted as income until April 1 of each year. A person is income-eligible:

- (a) For SLMB when their countable income is within the range specified in 388-478-0085(2);
- (b) For ESLMB when:
 - (i) Their countable income is within the range specified in WAC 388-478-0085(3); and
 - (ii) They are not otherwise eligible for categorically needy (CN) or medically needy (MN) coverage; and
 - (iii) Until December 31st of each year or until the date that the annual allotment of federal funds is exhausted.

(5) Clients who are eligible for categorically needy (CN) or medically needy (MN) medical coverage, but not eligible for QMB or SLMB programs may be eligible for a third Medicare cost-sharing program. If they are eligible for or receiving Medicare Part A coverage, they receive the state-funded buy-in program. Under the buy-in program the department pays the following:

- (a) Their Medicare Part A premiums, if any; and
- (b) Their Medicare Part B premiums; and
- (c) Their Medicare Part B coinsurance, and deductibles.

(6) Clients who are not eligible for QMB, SLMB or buy-in may be eligible for assistance with their Medicare out-of-pocket costs. Clients who meet the following conditions have their Medicare Part A premium(s) paid for them under the QDWI program. A person is income-eligible for QDWI when:

- (a) They are not otherwise eligible for CN or MN medical coverage; and
- (b) They are eligible for Medicare Part A; and
- (c) Their countable income does not exceed the standard in WAC 388-478-0085(4).

(7) Persons not eligible for any other Medicare cost-sharing program discussed in this section may receive compensation of one dollar and seven cents per month under the QI program. Total reimbursement is limited to the amount of money made available for this program from the federal government. The benefit is payable annually as partial reimbursement of their Medicare Part B premiums. A person is income-eligible for QI when:

- (a) They are not otherwise eligible for CN or MN medical coverage; and
- (b) Their countable income does not exceed the standard in WAC 388-478-0085(5).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-517-0300, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1710, 388-517-1730, 388-517-1750 and 388-517-1770.]

Chapter 388-519 WAC
SPENDDOWN

WAC

388-519-0100	Eligibility for the medically needy program.
388-519-0110	Spenddown of excess income for the medically needy program.
388-519-0120	Spenddown—Medically indigent program.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-519-1905

Base period. [Statutory Authority: RCW 74.08.090 and Budget Note 17. 96-16-092, § 388-519-1905, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090, 95-22-039 (Order 3913, #100246), § 388-519-1905, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-519-1905, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-055.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-416-0025 and 388-519-0120.

Allowable income deductions and exemptions. [Statutory Authority: RCW 74.08.090, 96-14-057 (Order 3986), § 388-519-1910, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1910, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-020 (part).] Repealed by 98-16-050, filed 7/31/98, effective

388-519-1930	9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-450-0020, 388-450-0110, 388-450-0150, 388-450-0210 and 388-519-0110.	(5) A person who meets the above conditions is eligible for MN medical coverage if their MN countable income is at or below the medically needy income level (MNIL) in WAC 388-478-0070. They are certified as eligible for up to twelve months of MN medical coverage. Certain SSI or SSI-related clients have a special MNIL. That MNIL exception is described in WAC 388-513-1305.
388-519-1950	Computing spenddown; allowable spenddown expenses. [Statutory Authority: RCW 74.08.090, 96-14-057 (Order 3986), § 388-519-1930, filed 6/27/96, effective 7/28/96; 94-10-065 (Order 3732), § 388-519-1930, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-99-020 and 388-99-030.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-519-0110, 388-519-0100 and 388-476-0070.	(6) A person whose MN countable income exceeds the MNIL may become eligible for MN medical coverage when they have or expect to have medical expenses. Those medical expenses or obligations may be used to offset any portion of their income which is over the MNIL.
	Institutional spenddown. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-519-1950, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090.	(7) That portion of a person's MN countable income which is over the department's MNIL standard is called "excess income."

WAC 388-519-0100 Eligibility for the medically needy program. (1) A person who meets the following conditions is considered for medically needy (MN) coverage under the special rules in chapter 388-513 WAC.

(a) A person who meets the institutional status requirements of WAC 388-513-1320; or

(b) A person who receives waiver services under chapter 388-515 WAC.

(2) MN coverage is considered under this chapter when a person:

(a) Is not excluded under subsection (1) of this section; and

(b) Is not eligible for categorically needy (CN) medical coverage because they have CN countable income which is above the CN income standard.

(3) MN coverage is available for children, for persons who are pregnant or for persons who are SSI-related. MN coverage is available to an aged, blind, or disabled ineligible spouse of an SSI recipient even though that spouse's countable income is below the CN income standard. Adults with no children must be SSI related in order to be qualified for MN coverage.

(4) A person not eligible for CN medical and who is applying for MN coverage has the right to income deductions in addition to those used to arrive at CN countable income. The following deductions are used to calculate their countable income for MN. Those deductions to income are applied to each month of the base period and determine MN countable income:

(a) All health insurance premiums expected to be paid by the client during the base period are deducted from their income; and

(b) For persons who are SSI-related and who are married, see the income provisions for the nonapplying spouse in WAC 388-450-0210; and

(c) For persons who are not SSI-related and who are married, an income deduction is allowed for a nonapplying spouse:

(i) If the nonapplying spouse is living in the same home as the applying person; and

(ii) The nonapplying spouse is receiving community and home based services under chapter 388-515 WAC; then

(iii) The income deduction is equal to the one person MNIL less the nonapplying spouse's actual income.

(5) A person who meets the above conditions is eligible for MN medical coverage if their MN countable income is at or below the medically needy income level (MNIL) in WAC 388-478-0070. They are certified as eligible for up to twelve months of MN medical coverage. Certain SSI or SSI-related clients have a special MNIL. That MNIL exception is described in WAC 388-513-1305.

(6) A person whose MN countable income exceeds the MNIL may become eligible for MN medical coverage when they have or expect to have medical expenses. Those medical expenses or obligations may be used to offset any portion of their income which is over the MNIL.

(7) That portion of a person's MN countable income which is over the department's MNIL standard is called "excess income."

(8) When a person has or will have "excess income" they are not eligible for MN coverage until they have medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown."

(9) A person who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter a person is ineligible for MN coverage if their resources exceed the program standard in WAC 388-478-0070. A person who is considered for MN coverage under chapter 388-513 WAC is allowed to spenddown excess resources.

(10) No extensions of coverage or automatic redetermination process applies to MN coverage. A client must submit an application for each eligibility period under the MN program.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-519-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0320, 388-518-1840, 388-519-1930 and 388-522-2230.]

WAC 388-519-0110 Spenddown of excess income for the medically needy program. (1) The person applying for MN medical coverage chooses a three month or a six month base period for spenddown calculation. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section apply.

(2) A person's base period begins on the first day of the month of application, subject to the exceptions in subsection (4) of this section.

(3) A separate base period may be made for a retroactive period. The retroactive base period is made up of the three calendar months immediately prior to the month of application.

(4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:

(a) A three month base period would overlap a previous eligibility period; or

(b) A client is not or will not be resource eligible for the required base period; or

(c) The client is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

(d) The client is or will be eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The client was not otherwise eligible for MN coverage for each of the months of the retroactive base period.

(5) The amount of a person's "spenddown" is calculated by the department. The MN countable income from each month of the base period is compared to the MNIL. The excess income from each of the months in the base period is added together to determine the "spenddown" for the base period.

(6) If income varies and a person's MN countable income falls below the MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 388-519-0100(5).

(7) Once a person's spenddown amount is known, their qualifying medical expenses are subtracted from that spenddown amount to determine the date of eligibility. The following medical expenses are used to meet spenddown:

(a) First, Medicare and other health insurance deductibles, coinsurance charges, enrollment fees, or copayments;

(b) Second, medical expenses which would not be covered by the MN program;

(c) Third, hospital expenses paid by the person during the base period;

(d) Fourth, hospital expenses, regardless of age, owed by the applying person;

(e) Fifth, other medical expenses, potentially payable by the MN program, which have been paid by the applying person during the base period; and

(f) Sixth, other medical expenses, potentially payable by the MN program which are owed by the applying person.

(8) If a person meets the spenddown obligation at the time of application, they are eligible for MN medical coverage for the remainder of the base period. The beginning date of eligibility would be determined as described in WAC 388-416-0020.

(9) If a person's spenddown amount is not met at the time of application, they are not eligible until they present evidence of additional expenses which meets the spenddown amount.

(10) To be counted toward spenddown, medical expenses must:

(a) Not have been used to meet a previous spenddown; and

(b) Not be the confirmed responsibility of a third party. The entire expense will be counted unless the third party confirms its coverage within:

(i) Forty-five days of the date of the service; or

(ii) Thirty days after the base period ends; and

(c) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period and be for services for:

(A) The applying person; or

(B) A family member legally or blood-related and living in the same household as the applying person.

(ii) Be for services received and paid for during the base period; or

(iii) Be for services received and paid for during a previous base period if that client payment was made necessary due to delays in the certification for that base period.

(1999 Ed.)

(11) An exception to the provisions in subsection (10) of this section exists. Medical expenses the person owes are applied to spenddown even if they were paid by or are subject to payment by a publicly administered program during the base period. To qualify, the program cannot be federally funded or make the payments of a person's medical expenses from federally matched funds. The expenses do not qualify if they were paid by the program before the first day of the base period.

(12) The following medical expenses which the person owes are applied to spenddown. Each dollar of an expense or obligation may count once against a spenddown cycle that leads to eligibility for MN coverage:

(a) Charges for services which would have been covered by the department's medical programs as described in chapter 388-529 WAC, less any confirmed third party payments which apply to the charges; and

(b) Charges for some items or services not typically covered by the department's medical programs, less any third party payments which apply to the charges. The allowable items or services must have been provided or prescribed by a licensed health care provider; and

(c) Medical insurance and Medicare copayments or coinsurance (premiums are income deductions under WAC 388-519-0100(4)); and

(d) Medical insurance deductibles including those Medicare deductibles for a first hospitalization in sixty days.

(13) Medical expenses may be used more than once if:

(a) The person did not meet their total spenddown amount and did not become eligible in that previous base period; and

(b) The medical expense was applied to that unsuccessful spenddown and remains an unpaid bill.

(14) To be considered toward spenddown, written proof of medical expenses must be presented to the department. The deadline for presenting medical expense information is thirty days after the base period ends unless good cause for delay can be documented.

(15) Once a person meets their spenddown and they are issued a medical identification card for MN coverage, newly identified expenses cannot be considered toward that spenddown. Once the application is approved and coverage begins the beginning date of the certification period cannot be changed due to a client's failure to identify or list medical expenses.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1830, 388-518-1840, 388-519-1905, 388-519-1910, 388-519-1930 and 388-522-2230.]

WAC 388-519-0120 Spenddown—Medically indigent program. (1) Persons ineligible for CN or MN coverage are considered for the medically indigent (MI) program under chapter 388-438 WAC. Medically indigent spenddown differs from medically needy spenddown in the following ways:

(a) In addition to spending down income in excess of the MNIL, the amount of countable resources which is in excess of the standard in WAC 388-478-0070 is spent down.

[Title 388 WAC—p. 647]

(b) The base period for MI begins on the first day of the month in which the following occurred:

- (i) Emergency ambulance transportation; or
- (ii) Hospital emergency room services were received; or
- (iii) The person was hospitalized for the emergency condition.

(c) The base period for MI is three months and it can join retroactive and prospective months into the same base period.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-519-0120, filed 7/31/98, effective 9/1/98. Formerly WAC 388-519-1905.]

Chapter 388-523 WAC MEDICAL EXTENSIONS

WAC

388-523-0100 Medical extensions.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-523-2305 Medical extensions. [Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, § 388-523-2305, filed 7/13/98, effective 7/30/98. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-523-2305, filed 5/3/94, effective 6/3/94. Formerly WAC 388-83-029.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.

388-523-2320 Medicaid quarterly reporting. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-523-2320, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-523-0100.

WAC 388-523-0100 Medical extensions. (1) A family who received temporary assistance for needy families (TANF) or state family assistance (SFA) cash or related medical assistance in any three of the last six months is eligible for extended medical benefits when they are ineligible for TANF/SFA-related medical because:

(a) They receive child or spousal support, which exceeds the payment standard described in WAC 388-478-0020, and they are not eligible for any other categorically needy (CN) medical program; or

(b) Their earnings increased resulting in income exceeding the TANF/SFA payment standard described in subsection (1)(a).

(2) A family described in subsection (1)(a) is eligible to receive four months of extended medical benefits beginning the month after termination from cash or TANF/SFA-related medical assistance, provided the family includes a child as defined in WAC 388-404-0005.

(3) A family described in subsection (1)(b) is eligible to receive six months of extended medical benefits when:

(a) They continue to meet the eligibility requirements of a TANF/SFA-related medical program, other than income; and

(b) The family includes a child.

(4) A family described in subsection (3) will not receive extended medical benefits for any family member who has been found ineligible for cash assistance because of fraud in any of the six months prior to the extended medical period.

(5) A family receiving extended medical benefits described in subsection (4) of this section is eligible for up to an additional six calendar months of extended medical benefits as long as:

(a) The family continues to include a child; and

(b) The family's gross earned income, after child care deductions in the preceding three months averages less than, one hundred eighty-five percent of the Federal Poverty Level (FPL), as described in WAC 388-478-0075; and

(c) A caretaker relative has had earnings in each of the three previous months, prior to the month of request for the second six month extension; and

(d) The family reports to the department family earnings and child care costs relating to employment by the twenty-first day of the:

(i) Fourth month of the initial six month extension period; and

(ii) First month of the second six month extension; and

(iii) Fourth month of the second six month extension.

(6) Certain circumstances may prevent a family from meeting the requirements in subsection (5)(b), (c) and (d) of this section. If that occurs, good cause may exist and the family remains eligible for the additional six month medical extension. Reasons for good cause include, but are not limited to:

(a) Illness, mental impairment, injury, trauma, or stress; or

(b) Lack of understanding the reporting requirement due to a language barrier; or

(c) Transportation problems; or

(d) Payment for work in each month of the reporting period was paid in a different month than it was earned; or

(e) The client expected to be able to meet the family medical needs, but could not; or

(f) The client was given incorrect information about the reporting requirements.

(7) Postpartum and family planning extensions are described in WAC 388-462-0015.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-523-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-522-2210, 388-523-2305 and 388-523-2320.]

Chapter 388-526 WAC MEDICAL FAIR HEARINGS

WAC

388-526-2610 Fair hearings.

WAC 388-526-2610 Fair hearings. (1) A client aggrieved by a department decision shall have a right to a fair hearing as provided under chapter 388-08 WAC.

(2) Medical assistance administration shall be responsible for a prehearing review when the fair hearing request questions a decision:

(a) Of a medical consultant; or

(b) Concerning an eligibility determination in the Medicaid category or state-funded medical program.

(3) Medical assistance administration shall review all fair hearing requests referred by the fair hearing coordinator to determine whether or not the:

(a) Appellant's request for service was filed according to the applicable rules and regulations;

(b) Decision has been made upon complete and accurate evaluation of the facts, existing standards, regulations, and policies.

(4) All records and information necessary to determine the validity of the appellant's fair hearing request on request to the reviewing authority and forwarded not later than ten days from such request.

(5) The examiner or the appellant may obtain a medical assessment by a professionally qualified person not a party to the action being appealed, at the request of the examiner or the appellant.

(6) On receipt of the necessary material, evidence, or reports, the designated reviewing authority shall evaluate the appellant's request in accord with existing rules, regulations, and policies of the department. The reviewing authority may:

(a) Reverse the decision when such adverse decision has been made contrary to the rules, regulations and policies of medical assistance administration;

(b) Resolve a situation resulting in the fair hearing request by adjustment.

(7) In providing a system for fair hearings for medical care clients, the department shall follow the rules in chapter 388-08 WAC and, where appropriate, other portions of the rules which are applicable to the particular circumstances of the appellant.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-526-2610, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-040.]

Chapter 388-527 WAC

MEDICAL OVERPAYMENT/REPAYMENT

WAC

388-527-2730	Estate recovery definitions.
388-527-2735	Liability for medical care.
388-527-2740	Age when recovery applies.
388-527-2742	Services subject to recovery.
388-527-2750	Waiver of recovery if undue hardship.
388-527-2752	Deferring recovery.
388-527-2753	No liability for medical care.
388-527-2754	Assets not subject to recovery.
388-527-2790	Filing of a lien against real property.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-527-2710 Recovery from estates. [Statutory Authority: RCW 74.08.090 and OBRA 1993, HB 2492. 94-17-035 (Order 3768), § 388-527-2710, filed 8/10/94, effective 9/10/94. Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-527-2710, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-047.] Repealed by 95-19-001 (Order 3893), filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18.

388-527-2720 Restitution. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-527-2720, filed 5/3/94, effective 6/3/94. Formerly WAC 388-81-050] Repealed by 95-19-001 (Order 3893), filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18.

WAC 388-527-2730 Estate recovery definitions.

(1)(a) For estate recovery purposes, "estate" includes:

(i) For a client who dies before July 1, 1995 all real and personal property and any other assets that pass upon the client's death:

(A) Under the client's will;

(B) By intestate succession pursuant to chapter 11.04 RCW; or

(C) Under chapter 11.62 RCW; or

(ii) For a client who dies after June 30, 1995 all real and personal property and any other assets that pass upon the client's death:

(A) Under the client's will;

(B) By intestate succession pursuant to chapter 11.04 RCW; or

(C) Under chapter 11.62 RCW; and

(D) Nonprobate assets as defined by RCW 11.02.005, except property passing through a community property agreement.

(b) The value of the estate shall be reduced by any valid liability against the deceased client's property at the time of death.

(2) "Long-term care services" means the services administered directly or through contract by the aging and adult services administration of the department, including but not limited to nursing facility care and home and community services. "State-funded long-term care" means the long-term care services that are paid with state funds and do not include federal funds.

(3) "Medical assistance" means the federal aid medical care program provided to categorically needy persons as defined under Title XIX of the Federal Social Security Act.

[Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2730, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2735 Liability for medical care. (1) A client's estate may be liable for the cost of medical care the department correctly paid on the client's behalf.

(2) The rules in this chapter state when the client's estate is liable for medical care the department paid and when the department shall seek recovery.

[Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2735, filed 9/6/95, effective 10/7/95.]

WAC 388-527-2740 Age when recovery applies. Whether the client's estate is liable for the cost of medical care provided depends, in part, upon the client's age and when the services were received. Subsection (1) of this section covers liability for medical assistance and subsection (2) covers liability for state-funded long-term care services. An estate may be liable under both subsections.

(1)(a) If a client was age sixty-five or older on July 1, 1994, the estate is liable for medical assistance subject to recovery provided on and after the date the client became age sixty-five.

(b) If the client was age fifty-five through sixty-four years of age on July 1, 1994, the estate is liable for medical assistance subject to recovery provided on and after July 1, 1994.

(c) If a client was under age fifty-five on July 1, 1994, the estate is liable for medical assistance subject to recovery provided on and after the date the client became age fifty-five.

(2) The estate is liable for state-funded long-term care services provided on and after July 1, 1995 regardless of the client's age when the services were provided.

[Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090, 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2740, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2742 Services subject to recovery. Whether the client's estate is liable for medical care provided depends, in part, upon what medical services the client received and the dates when services were provided. Subsection (1) of this section covers liability for medical assistance and subsection (2) covers liability for state-funded long-term care services. An estate can be liable under both subsections.

(1)(a) The estate is liable for all medical assistance services provided before July 1, 1994;

(b) The estate is liable for the following medical assistance services provided after June 30, 1994 and before July 1, 1995:

- (i) Nursing facility services;
- (ii) Home and community-based services; and
- (iii) Related hospital services and prescription drug services.

(c) The estate is liable for the following medical assistance services provided after June 30, 1995:

- (i) Nursing facility services;
- (ii) Home and community-based services;
- (iii) Adult day health;
- (iv) Medicaid personal care;
- (v) Private duty nursing administered by the aging and adult services administration of the department; and
- (vi) Related hospital and prescription drugs services.

(2) The estate is liable for all state-funded long-term care services and related hospital and prescription drug services provided after June 30, 1995.

[Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18, 95-19-001 (Order 3893), § 388-527-2742, filed 9/6/95, effective 10/7/95.]

WAC 388-527-2750 Waiver of recovery if undue hardship. The department shall waive recovery under this section when recovery would work an undue hardship except as provided in subsection (3) of this section. This waiver is limited to the period during which undue hardship exists.

(1) Undue hardship exists when:

(a) The estate subject to adjustment or recovery is the sole income-producing asset of one or more of the heirs and income is limited; or

(b) Recovery would result in the impoverishment of one or more of the heirs; or

(c) Recovery would deprive an heir of shelter and the heir lacks the financial means to obtain and maintain alternative shelter.

(2) Undue hardship does not exist when:

(a) The adjustment or recovery of the client's cost of assistance would merely cause the client's family members inconvenience or restrict the family's lifestyle.

(b) The heir divests assets to qualify under the undue hardship provision.

(3) The department shall not waive recovery based on undue hardship when a deceased client's assets were disregarded in connection with a long-term care insurance policy or contract under chapter 48.85 RCW.

(4) A person who requests the department to waive recovery in whole or in part, and who suffers a loss because the request is not granted, may contest the department's decision in an adjudicative proceeding. The department's decision shall state the requirements for an application for an adjudicative proceeding and state where assistance might be obtained to make an application. The proceeding shall be governed by chapters 34.05 RCW and 388-08 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-08 WAC, the provision in this section governs. An application for an adjudicative proceeding must:

- (a) Be in writing;
- (b) State the basis for contesting the department's denial of the request to waive recovery;

(c) Include a copy of the department's denial of the request to waive recovery;

(d) Be signed by the applicant and the state and include the applicant's address and telephone number;

(e) Be served within twenty-eight days of the date the applicant received the department's decision denying the request for a waiver. An application filed up to thirty days late may be treated as if timely filed if the applicant shows good cause for filing late; and

(f) Be served on the office of financial recovery in a manner which shows proof of receipt, such as personal service or certified mail, return receipt requested. The mailing address of the Office of Financial Recovery is: P.O. Box 9501, Olympia WA 98507-9501. The physical location of the Office of Financial Recovery is Capitol View Building, Second Floor, 712 Pear Street Southeast, Olympia, Washington.

[Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090, 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2750, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2752 Deferring recovery. If the client died after June 30, 1994 the department shall defer recovery from the estate until:

- (1) The death of the surviving spouse, if any, and
- (2) There is no surviving child who is:
 - (a) Under twenty-one years of age, or
 - (b) Blind or disabled as defined under chapter 388-511 WAC.

[Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090, 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2752, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2753 No liability for medical care. The client's estate is not liable when the client died before July 1, 1994 and on the date of death there was:

- (1) A surviving spouse; or
- (2) A surviving child who was either:
 - (a) Under twenty-one years of age; or
 - (b) Blind or disabled as defined under chapter 388-511 WAC.

[Statutory Authority: RCW 74.08.090 and 1995 1st sp.s. c 18. 95-19-001 (Order 3893), § 388-527-2753, filed 9/6/95, effective 10/7/95.]

WAC 388-527-2754 Assets not subject to recovery.

(1) If a client died before July 25, 1993 with no surviving spouse or blind or disabled child, but with a surviving child, recovery does not apply to the first fifty thousand dollars of the estate value at the time of death and recovery is limited to thirty-five percent of the remaining value of the estate.

(2) If a client died after July 24, 1993 and before July 1, 1994, the department shall not seek recovery against the following property, up to a fair market value of two thousand dollars, from the estate of the client:

- (a) Family heirlooms,
- (b) Collectibles,
- (c) Antiques,
- (d) Papers,
- (e) Jewelry,
- (f) Photos, and

(g) Other personal effects of the deceased client and to which a surviving child is entitled.

[Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2754, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

WAC 388-527-2790 Filing a lien against real property. (1) The department shall file liens, seek adjustment, or otherwise effect recovery for medical assistance or state-funded long-term care, or both, correctly paid on behalf of a client as required by 42 U.S.C. 1396p and chapters 43.20B RCW and 388-527 WAC.

(2) When the department seeks to recover from a client's estate the cost of medical assistance or state-funded long-term care, or both, provided to the client, prior to filing a lien against the deceased client's real property, the department shall provide notice to:

- (a) The probate estate's personal representative, if any;
- (b) The decedent's surviving spouse, if any; or
- (c) Any other person having title to the affected property.

(3) Prior to filing a lien against any of the deceased client's real property, the department shall provide ascertained persons having title to the property notice and an opportunity for an adjudicative proceeding. The department shall:

(a) Serve upon ascertained persons having title to the property a notice of intent to file lien, which shall state:

(i) The deceased client's name, social security number, if known, date of birth, and date of death;

(ii) The amount of medical assistance, or state-funded long-term care, or both, correctly paid on behalf of the deceased client the department seeks to recover;

(iii) The department's intent to file a lien against the deceased client's real property to recover the medical assistance or state-funded long-term care, or both, correctly paid on behalf of the deceased client;

(iv) The county in which the real property is located; and

(v) The right of the ascertained person having title to the property to contest the department's decision to file a lien by filing an application for an adjudicative proceeding with the office of financial recovery; and

(b) Provide an adjudicative proceeding to determine whether:

(i) The amount of medical assistance or state-funded long-term care, or both, correctly paid on behalf of the deceased client alleged by the department's notice of intent to file lien is correct; and

(ii) The deceased client had any legal title to the real property at the time of the client's death.

(4) An application for an adjudicative proceeding must:

(a) Be in writing;

(b) State the basis for contesting the department's notice of intent to file lien;

(c) Be signed by the applicant and state the applicant's address and telephone number;

(d) Be served on the office of financial recovery within twenty-eight days of the date the applicant received the department's notice of intent to file lien. An application filed up to thirty days late may be treated as timely filed if the applicant shows good cause for filing late; and

(e) Be served on the office of financial recovery in a manner in which shows proof of receipt, such as personal service or certified mail, return receipt requested. The mailing address of the Office of Financial Recovery is P.O. Box 9501, Olympia WA 98507-9501. The physical location of the Office of Financial Recovery is Capitol View Building, Second Floor, 712 Pear Street Southeast, Olympia, Washington.

(5) Upon receipt of an application for an adjudicative proceeding, the department shall provide notice of the proceeding to all other ascertained persons having title to the property.

(6) An adjudicative proceeding under this section shall be governed by chapters 34.05 RCW and 388-08 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-08 WAC, the provision in this section governs.

(7) If no ascertained person having title to the property files an application for an adjudicative proceeding within twenty-eight days of the date the department served a notice of intent to file lien, the department shall file a lien. The department shall file a lien against the deceased client's real property for the amount of medical assistance or state-funded long-term care, or both, correctly paid on behalf of the deceased client alleged in the notice of intent to file lien.

[Statutory Authority: 1995 1st sp.s. c 18 and RCW 74.08.090. 95-19-001 and 95-24-037 (Orders 3893 and 3893A), § 388-527-2790, filed 9/6/95 and 11/29/95, effective 10/7/95 and 12/30/95.]

Chapter 388-529 WAC
SCOPE OF MEDICAL SERVICES

WAC

388-529-0100 Scope of covered medical services by program.

388-529-0200 Medical services available to eligible clients.

388-529-2940 Scope of care—Children's health.

388-529-2950 Scope of care—Medically indigent.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-529-2910

Scope of care—Categorically needy. [Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2910, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-529-0100.

388-529-2920	Scope of care—Medically needy. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-529-2920, filed 5/3/94, effective 6/3/94. Formerly WAC 388-99-060.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-529-0100.
388-529-2930	Scope of care—GAU/ADATSA—Medical care services. [Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-529-2930, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-529-0100.
388-529-2960	Scope of care—Qualified Medicare beneficiary (QMB), special low-income Medicare beneficiary and qualified disabled working individual (QDWI). [Statutory Authority: RCW 74.04.050, 74.08.090 and 74.09.510. 98-04-004, § 388-529-2960, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-529-2960, filed 5/3/94, effective 6/3/94.] Repealed by 98-16-050, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. Later promulgation, see WAC 388-517-0100.

WAC 388-529-0100 Scope of covered medical services by program. (1) The scope of medical care which clients can receive is based on the medical program for which they are eligible. Clients eligible for the following medical programs have coverage for the medically necessary services indicated in the specific columns in the chart provided in WAC 388-529-0200:

(a) Categorically needy (CN) medical coverage is provided as described in the "CN" column. Coverage is modified by the provisions in this section and those found in chapter 388-86 WAC;

(b) Medically needy (MN) medical coverage is provided as described in the "MN" column and as modified in this section and in chapter 388-86 WAC;

(c) General assistance - unemployable (GAU) or alcohol and drug abuse treatment and support act (ADATSA) medical coverage is provided as described in the "MCS" column. Coverage is modified by the provisions in WAC 388-86-120;

(d) The state-funded children's health program has medical coverage as described in the "CN" column and in subsection (1)(a) of this section;

(e) State-funded medically indigent (MI) program has medical coverage as described in the "MI" column to the extent that services are related to the qualifying emergency condition. Coverage begins after the client has met the annual emergency medical expense requirement (EMER) as described in WAC 388-438-0100.

(f) Pregnant undocumented aliens have medical coverage as described in the "CN" column and in subsection (1)(a) of this section.

MEDICAL SERVICES

Adult day health			
Advanced RN practitioner services			
Ambulance/ground and air			
Anesthesia services			
Audiology (hearing exams)			
Blood/blood derivatives/			
Blood administration			
Case management - maternity			

(2) "Medically necessary" is a standard for coverage of services under the CN and MN programs. The term is defined in WAC 388-500-0005.

(3) Entries in WAC 388-529-0200 have the following meanings and conditions:

(a) "Yes":

(i) The service must be medically necessary as defined by the program; and

(ii) The service may have conditions placed on coverage in order to ensure that medical necessity exists. Examples are:

(A) The prior authorization requirement,

(B) The primary care provider referral requirement,

(C) The limit on eyeglasses to be covered for adults only once in a twenty-four-month period without documentation of special circumstances, etc.

(b) "HK" - the services are provided to children under the healthy kids program as described in WAC 388-86-027. This is consistent with the broader scope of coverage under the healthy kids program.

(c) "No" - This entry is used to describe coverage limitations of state-funded programs and indicates that the services are not covered. However, medically necessary services may be available under an "exception to rule" as described in chapter 388-440 WAC.

(d) "L" - the services are provided under limited circumstances described further under WAC 388-529-0200.

(e) "R" - the services are provided only as they are directly connected to emergency medical conditions. These program restrictions are described in WAC 388-438-0100.

(4) Coverage described in this chapter may be further limited by the notations defined in WAC 388-529-0200 and the provisions in chapters 388-86 and 388-87 WAC. Services may require prior authorization to ensure that medical necessity exists.

(5) Medical service categories not listed in WAC 388-529-0200 may not be covered under typical circumstances. Seeking specific coverage decisions in advance of service delivery is advised. Medical service providers may request authorization for any service which they see as medically necessary under WAC 388-501-0165.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090, 98-16-044, § 388-529-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0350, 388-529-2910, 388-529-2920 and 388-529-2930.]

WAC 388-529-0200 Medical services available to eligible clients. The following chart lists the medically necessary services available to clients eligible for a variety of assistance programs. Eligibility groups for CN, MCS, MN, and MI coverage are described in WAC 388-529-0100.

CN1/	MCS	MN	MI
Yes	Yes	Yes	No
Yes	Yes	Yes	No
Yes	Yes	Yes	R2/
Yes	Yes	Yes	R2/
Yes	Yes	HK only	No
Yes3/ L4/	Yes3/ No	Yes3/ L4/	R2/-3/ No

Chiropractic care	HK only	No	HK only	No
Clinic services	Yes	Yes	Yes	No
Community mental health centers	Yes	L5/	Yes	No
Dental services	Yes	No	Yes	No
Dentures only	Yes	Yes	Yes	No
Detoxification	Yes	Yes	Yes	Yes2/
Drugs and pharmaceutical supplies	Yes	Yes	Yes	No
Elective surgery	Yes	Yes	Yes	No
Emergency room services	Yes	Yes	Yes	R2/
Emergency surgery	Yes	Yes	Yes	R2/
Eyeglasses and exams	Yes6/	Yes6/	Yes6/	No
Family planning services7/	Yes	Yes	Yes	No
Healthy kids (HK) (EPSDT)	Yes	No	Yes	No
Hearing aids	Yes	Yes	HK only	No
Home health services	Yes	Yes	Yes	No
Hospice	Yes	No	Yes	No
Indian health clinics	Yes	No	Yes	No
Inpatient hospital care	Yes	Yes	Yes	R2/
Intermediate care facility/services for mentally retarded	Yes	Yes	Yes	N/A
Involuntary commitment	Yes	Yes	Yes	Yes2/
Maternity support services	Yes	No	Yes	No
Medical equipment, durable (DME)	Yes	Yes	Yes	No
Midwife services	Yes	Yes	Yes	R2/
Neuromuscular centers	Yes	No	Yes	No
Nursing facility services	Yes	Yes	Yes	Yes2/
Nutrition therapy	HK only	No	HK only	No
Optometry	Yes	Yes	Yes	No
Organ transplants	Yes	Yes	Yes	R2/
Out-of-state care	Yes	No	Yes	No
Outpatient hospital care	Yes	Yes	Yes	R2/
Oxygen/respiratory therapy	Yes	Yes	Yes	R2/
Pain management (chronic)	Yes	Yes	Yes	No
Personal care services	Yes8/	No	HK only8/	No
Physical/speech/occupational therapy	Yes	Yes	HK and L9/	No
Physical medicine and rehabilitation	Yes	Yes	Yes	R2/
Physician	Yes	Yes	Yes	R2/
Podiatry	Yes	Yes	Yes	No
Private duty nursing	L10/	L10/	L10/	No
Prosthetic devices/mobility aids	Yes	Yes	Yes	R2/
Psychiatric services	Yes	No	Yes	No
Psychological evaluation	L11/	L11/	L11/	No
Rural health services and Federally qualified health Centers (FQHC)	Yes	Yes	Yes	No
School medical services 12/	Yes	No	Yes	No
Substance abuse/outpatient	Yes	No	Yes	No
Surgical appliances	Yes	Yes	Yes	R2/
Total enteral/parenteral nutrition	Yes	Yes	Yes	No
Transportation other than ambulance	Yes	Yes	Yes	No
X-ray and lab services	Yes	Yes	Yes	R2/

(1) Notation 1/ indicates that the CN column applies to all categorically needy (CN) programs, the state-funded children's health program. It also describes the services available to pregnant women who are undocumented aliens.

(2) Notation 2/ restricts the coverage to those services directly connected to an emergency medical condition which requires hospital services. Emergency requirements are described in WAC 388-438-0100.

(3) Notation 3/ indicates that services are limited as described in WAC 388-87-045.

(4) Notation 4/ indicates that the services are limited to pregnant women who have been identified as being in a "high-risk" circumstance under WAC 388-86-017.

(5) Notation 5/ indicates that clients must meet the program definitions and program priorities of the community mental health act. Limited grants are available to counties for the funding of these services.

(6) Notation 6/ indicates that eyeglasses are limited under WAC 388-86-030. Special circumstances and specific

approval apply to more frequent services than those specified in WAC 388-86-030.

(7) Notation 7/ indicates that family planning services are available to all clients of the medical programs except for the medically indigent program. Some clients are eligible only for family planning services which is noted on the medical identification card. These services are described in WAC 388-462-0015.

(8) Notation 8/ indicates that services which are not medical services may be covered under certain qualifying conditions. These benefits are covered under the direction of the aging and adult services administration for CN eligible adults under home and community based programs; the division of developmental disabilities; or the children's services administration under WAC 388-86-087.

(9) Notation 9/ indicates that the services are not normally provided to clients, however, they are covered when the client is receiving department approved home health care services as described in WAC 388-86-045.

(10) Notation 10/ indicates that services are authorized according to the conditions listed in WAC 388-86-071.

(11) Notation 11/ indicates that the department limits services as described in WAC 388-86-067 and 388-86-095.

(12) Notation 12/ indicates a special medical program for children who are Medicaid eligible under an individualized education plan under the special education program of a school. This medical program is described further in WAC 388-86-022.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-529-0200, filed 7/31/98, effective 9/1/98. Formerly WAC 388-086-0015 and 388-086-0080.]

WAC 388-529-2940 Scope of care—Children's health. The department shall provide a child eligible for the children's health program categorically needy medical services. Refer to WAC 388-529-2910 for scope of care.

[Statutory Authority: RCW 74.08.090. 94-10-065 (Order 3732), § 388-529-2940, filed 5/3/94, effective 6/3/94.]

WAC 388-529-2950 Scope of care—Medically indigent. (1) The department shall provide coverage under the limited casualty program-medically indigent to an eligible person for treatment of emergency medical conditions requiring hospital-based care only. Services available are limited to:

(a) Medically necessary emergency air or ground ambulance; and
(b) Physician services related to hospital services.

(2) The department shall not pay for covered services until the client has medical expenses equal to the total of the emergency medical expense requirement of two thousand dollars and the spenddown, if any.

(3) The emergency medical expense requirement in WAC 388-518-1850 does not apply for treatment under the Involuntary Treatment Act (ITA). When any other medical need is identified for clients undergoing treatment under the ITA, the department shall apply the emergency medical expense requirement to the services other than ITA.

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(4) For other conditions and limitations under which the department may provide these services, refer to appropriate service in chapter 388-86 WAC.

(5) The department shall not provide a client out-of-state care except in the designated bordering cities.

[Statutory Authority: RCW 74.08.090. 95-22-039 (Order 3913, #100246), § 388-529-2950, filed 10/25/95, effective 10/28/95; 94-10-065 (Order 3732), § 388-529-2950, filed 5/3/94, effective 6/3/94. Formerly WAC 388-100-035.]

Chapter 388-530 WAC

PHARMACY SERVICES

WAC

388-530-1000	The medical assistance administration (MAA) drug program.
388-530-1050	Definitions.
388-530-1100	Covered drugs and pharmaceutical supplies.
388-530-1150	Noncovered drugs and pharmaceutical supplies.
388-530-1200	Drug formulary.
388-530-1250	Prior authorization.
388-530-1300	General reimbursement methodology.
388-530-1350	Estimated acquisition cost methodology.
388-530-1400	Maximum allowable cost methodology.
388-530-1450	Dispensing fee determination.
388-530-1500	Reimbursement for compounded prescriptions.
388-530-1550	Unit dose drug delivery systems.
388-530-1600	Unit dose pharmacy billing requirements.
388-530-1650	Reimbursement for pharmaceutical supplies.
388-530-1700	Drugs and pharmaceutical supplies from nonpharmacy providers.
388-530-1750	Drugs and pharmaceutical supplies for clients with any third-party coverage.
388-530-1800	Requirements for pharmacy claim payment.
388-530-1850	Drug utilization and education council.
388-530-1900	Drug use review.
388-530-1950	Point-of-sale (POS) system/prospective drug utilization review (Pro-DUR).
388-530-2050	Out-of-state prescriptions.

WAC 388-530-1000 The medical assistance administration (MAA) drug program. (1) The department shall reimburse providers for prescription drugs medically necessary to the health care of clients eligible for medical care programs in accordance with the department's rules.

(2) The pharmacy shall be an MAA provider as agreed under WAC 388-87-007.

(3) Acceptance and filling of a prescription drug for a client eligible for a medical care program constitutes acceptance of the department's rules and fees.

(4) The pharmacy shall bill the department and its clients according to WAC 388-87-010 and 388-87-015.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1000, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1050 Definitions. (1) "Actual acquisition cost (AAC)" means the actual price a provider paid for a drug marketed, in the package size of drug purchased, or sold by a particular manufacturer or labeler. Actual acquisition cost shall be calculated based on factors such as, but not limited to:

(a) Invoice price, including other invoice-based considerations;

(b) Order quantity and periodic purchase volume discount policies of suppliers (wholesalers and/or manufacturers);

(c) Membership/participation in purchasing cooperatives;

(d) Advertising and other promotion/display allowances, free merchandise deals; and
(e) Transportation or freight allowances.

(2) "**Administer**" means the direct application of a legend drug whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject by a practitioner, or to the patient or research subject at the direction of the practitioner.

(3) "**Authorized prescriber**" means a physician, osteopath, osteopathic physician/surgeon, dentist, nurse, physician assistant, optometrist, pharmacist, or other person duly authorized by law or rule in the state of Washington to prescribe drugs. See WAC 246-863-100 for pharmacists.

(4) "**Automated maximum allowable cost (AMAC)**" means the cost established for all multiple-source drugs designated by three or more products under federal contract and which are not on the maximum allowable cost (MAC) list.

(5) "**Average wholesale price (AWP)**" means the average price of a drug product from wholesalers nationwide at a point in time. MAA determines AWP as reported by a drug pricing file contractor.

(6) "**Brand name**" means the proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label or wrapping at the time of packaging.

(7) "**Bulk drug delivery system**" means the method in which the prescribed amount of a drug product is packaged and dispensed to the patient in one bulk container.

(8) "**Compounding**" is the professional practice of combining two or more drugs, as defined in subsection (20)(a) and (b) of this section, in the preparation of a prescription.

(9) "**Contract drugs**" are drugs manufactured or distributed by manufacturers/labelers who signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

(10) "**Controlled substance**" means a drug or substance, or an immediate precursor of such drug or substance, as designated by chapter 69.50 RCW.

(11) "**Covered outpatient drug**" means a drug approved for safety and effectiveness as a prescription drug under the federal Food, Drug, and Cosmetic Act, which is used for a medically accepted indication, and is not subject to the exceptions under WAC 388-530-1150, Noncovered drugs and pharmaceutical supplies.

(12) "**Deliver or delivery**" means the actual, constructive, or attempted transfer from one person to another of a drug or device whether or not there is an agency relationship.

(13) "**Department**" means the department of social and health services (DSS).

(14) "**DESI**" or "**less than effective drugs**" are drugs for which:

(a) Effective approval of the drug application has been withdrawn by the Food and Drug Administration (FDA) for safety or efficacy reasons as a result of the drug efficacy study implementation (DESI) review; or

(b) The secretary of the department of health and human services (DHHS) has issued a notice of an opportunity for a hearing under section 505(e) of the federal Food, Drug, and Cosmetic Act on a proposed order of the secretary to withdraw approval of an application for such drug under such sec-

tion because the secretary has determined the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling.

(15) "**Device**" means instruments, apparatus, and contrivances, including their components, parts and accessories, intended:

(a) For use in the diagnosis, cure, mitigation, treatment, or prevention of human disease; or

(b) To affect the human structure or any human function.

(16) "**Dispense**" means the interpretation of a prescription or order for a legend drug and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

(17) "**Dispense as written (DAW)**" means an instruction to the pharmacist forbidding substitution of a generic drug or a therapeutically equivalent product for the specific drug product prescribed.

(18) "**Dispensing fee**" means the fee the department sets to reimburse providers for provider administrative costs estimated by the department and, including but not limited to, compounding time and overhead expenses incurred in filling medical assistance prescriptions.

(19) "**Distribute**" means to deliver other than by administering or dispensing a legend drug.

(20) "**Double-blind drug study**" is a randomized trial in which a single patient undergoes a series of pairs of treatments, consisting of one active and one placebo per pair, with the order determined by random allocation. Appropriate treatment targets (signs, symptoms, or laboratory tests) are used as the measure of efficacy, and the trial is continued until efficacy is established or disproved.

(21) "**Drug**" means a substance:

(a) Recognized as a drug in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the United States, or official national formulary, or any supplement to any of the above publications;

(b) Intended for use in the diagnosis, cure, mitigation, treatment, or prevention of human disease;

(c) (Other than food, minerals, or vitamins) intended to affect the structure or any function of the human body; and

(d) Intended for use as a component of any article specified in clause (a), (b) or (c) of this subsection, excluding devices or their components, parts or accessories.

(22) "**Drug formulary**" means a list of outpatient drugs not requiring prior authorization except as listed in 388-530-1250(2), as developed by an appropriate committee or the drug use review (DUR) board.

(23) "**Drug pricing file contractor**" means the entity which has contracted to provide the department, at specified intervals, the latest information and/or database on drugs and related supplies produced, prepared, processed, packaged, labeled, distributed, marketed, or sold in the marketplace. Contractor-provided information includes, but is not limited to, identifying characteristics of the drug (national drug code, drug name, manufacturer/labeler, dosage form, and strength) for the purpose of identifying and facilitating payment for the drugs billed to MAA.

(24) "**Drug rebates**" means payments provided by pharmaceutical manufacturers to state Medicaid programs

under the terms of the manufacturers' agreements with the Department of Health and Human Services.

(25) "**Drug-related supplies**" means nonpharmaceutical items necessary for administration or delivery of a drug.

(26) "**Drug use review (DUR) program**" means a quality assurance program for covered outpatient drugs which assures that prescriptions are appropriate, are medically necessary, and are not likely to result in adverse medical outcomes.

(27) "**Emergency kit**" means a set of pharmaceuticals furnished to a nursing facility by the primary pharmacy which provides prescription dispensing services to that facility. Each kit is specifically set up to meet the individual needs of each nursing facility.

(28) "**Estimated acquisition cost (EAC)**" means the department's best estimate of the price providers generally and currently pay for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.

(29) "**Expedited prior authorization**" means the process for authorizing selected drugs in which providers use a set of numeric codes to indicate to the department which acceptable indications/conditions/diagnoses/criteria are applicable to a particular request for drug authorization.

(30) "**Experimental drugs**" means drugs the FDA has not approved, or approved drugs when used for medical indications other than those listed by the FDA.

(31) "**Federal upper limit (FUL)**" means the maximum allowable payment set by the Health Care Financing Administration (HCFA) for a multiple source drug.

(32) "**Formulary**" means a drug formulary. See subsection (22) of this section for a definition of drug formulary.

(33) "**Generic code number**" means a number MAA uses regardless of manufacturer or package size to identify the generic formulation of a drug.

(34) "**Generic name**" means the official title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary.

(35) "**Ingredient cost**" means the portion of a prescription's cost attributable to the drug ingredients, chemical components, or substances.

(36) "**Label**" means a display of written, printed or graphic matter upon the immediate container of any article.

(37) "**Labeling**" means all labels and other written, printed, or graphic matter:

(a) Upon any article or any of its containers or wrappers; or

(b) Accompanying such article.

(38) "**Legend or prescription drugs**" means any drugs required by any applicable federal or state law or regulation to be dispensed by prescription only or which are restricted to use by practitioners only.

(39) "**Long-term therapy**" means treatment a client receives or will receive continuously through and beyond ninety days.

(40) "**Manufacture**" means:

(a) The production, preparation, propagation, compounding, or processing of a drug or other substance or device; or

(b) The packaging or repackaging of such substance or device; or

(c) The labeling or relabeling of the commercial container of such substance or device.

"Manufacture" does not include the activities of a practitioner who, as an incident to the practitioner's administration or dispensing such substance or device in the course of professional practice, prepares, compounds, packages, or labels such substance or device.

(41) "**Manufacturer**" means a person, corporation, or other entity engaged in the manufacture of drugs or devices.

(42) "**Maximum allowable cost (MAC)**" means the maximum amount that MAA will pay for a specific dosage form and strength of a multiple source drug product.

(43) "**Medically accepted indication**" means any use for a covered outpatient drug approved under the federal Food, Drug, and Cosmetic Act, which appears in peer-reviewed medical literature or which is accepted by one or more of:

(a) The American Hospital Formulary Service Drug Information;

(b) The American Medical Association Drug Evaluations; or

(c) The United States Pharmacopoeia Drug Information.

(44) "**Medicine cart system**" is a patient-specific set of pharmaceuticals prearranged in a medicine cart, for administration over a specified time period.

(45) "**Modified unit dose delivery system**" (also known as **blister** packs, "**bingo/punch cards**") means a method in which each patient's medication is delivered:

(a) In individually sealed, single dose packages or "blisters;"

(b) Usually on one card; and

(c) In quantities for one month's supply, unless the prescriber specifies short-term therapy.

(46) "**Multiple-source drug**" means a drug marketed or sold by:

(a) Two or more manufacturers or labelers; or

(b) The same manufacturer or labeler:

(i) Under two or more different proprietary names; or

(ii) Both under a proprietary name and without such a name.

(47) "**National drug code (NDC)**" means the eleven-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging which identifies the product's manufacturer, dose form and strength, and package size.

(48) "**Noncontract drugs**" are drugs manufactured or distributed by manufacturers/labelers who have not signed a drug rebate agreement with the federal Department of Health and Human Services.

(49) "**Nonlegend or nonprescription drugs**" means any drugs which may be lawfully sold without a prescription.

(50) "**Nursing home pharmacy**" means a pharmacy serving primarily clients residing in nursing facilities.

(51) "**Obsolete NDC**" means a national drug code replaced or discontinued by the manufacturer or labeler.

(52) "**On-line receipt of claims**" means claims information received from a switching vendor in a National Council for Prescription Data Processing-approved format.

(53) "Outpatient pharmacy" means a pharmacy serving primarily outpatient clients.

(54) "Over-the-counter (OTC) drugs" mean drugs that do not require a prescription before they can be dispensed.

(55) "Pharmacist" means a person duly licensed by the Washington State Board of Pharmacy to engage in the practice of pharmacy.

(56) "Pharmacist consultant" means a registered pharmacist employed by MAA.

(57) "Pharmacy" means every site, properly licensed by the Washington State Board of Pharmacy, in which the practice of pharmacy is conducted.

(58) "Point-of-sale (POS)" means a pharmacy claims processing system capable of receiving and adjudicating claims on-line.

(59) "Practice of pharmacy" means the practice of and responsibility for:

(a) Interpreting prescription orders;

(b) Compounding, dispensing, labeling, administering, and distributing of drugs and devices;

(c) Monitoring of drug therapy and use;

(d) Initiating or modifying of drug therapy in accordance with written guidelines or protocols previously established and approved for a pharmacist's practice by a practitioner authorized to prescribe drugs;

(e) Participating in drug utilization reviews and drug product selection;

(f) Proper and safe storing and distribution of drugs and devices and maintenance of proper records thereof; and

(g) Providing legend drug information which includes, but is not limited to, the advising of therapeutic values, hazards, and the uses of drugs and devices.

(60) "Practitioner" means one who has met the professional and legal requirements necessary to provide a health care service, such as a physician, nurse, dentist, physical therapist, pharmacist or other person duly authorized by Washington state law as a practitioner.

(61) "Prescription" means an order for drugs or devices issued by a practitioner duly authorized by Washington state law or rule to prescribe drugs or devices in the course of the practitioner's professional practice for a legitimate medical purpose.

(62) "Prospective drug use review (Pro-DUR)" means a process in which a request for a drug product for a particular patient is screened, before the product is dispensed, for potential drug therapy problems.

(63) "Reconstitution" means the process of returning a substance, previously altered for preservation and storage, to its approximate original state.

(64) "Retrospective drug use review (Retro-DUR)" is the process in which patient drug use is reviewed on a periodic basis to identify patterns of fraud, abuse, gross overuse, or inappropriate or unnecessary care.

(65) "Single source drug" means a drug produced or distributed under an original new drug application approved by the FDA, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

(66) "Standard package size" means MAA's designated standard package or container size for a drug dosage form and/or strength for reimbursement purposes.

(67) "Substitute" means to dispense:

(a) With the practitioner's authorization, a therapeutically equivalent generic drug product of the identical base or salt as the specific drug product prescribed; or

(b) With the practitioner's prior consent, therapeutically equivalent drugs other than the identical base or salt.

(68) "Terminated drug product" is a product whose shelf life expiration date has been met, per manufacturer notification.

(69) "Therapeutically equivalent" means of essentially the same efficacy and toxicity when administered to an individual in the same dosage regimen.

(70) "Tiered dispensing fee system" means a method of paying pharmacies different dispensing fee rates.

(71) "True unit dose delivery" means a drug delivery system in which each patient's medication is delivered to the nursing facility in quantities sufficient only for the day's required dosage. If a medication cart system is used, the pharmacy may deliver the medication cart to the nursing facility every other day, and provide for daily service as needed.

(72) "Unit dose drug delivery systems" mean true unit and modified unit dose or blister packs, also known as "bingo" or punch cards.

(73) "Usual and customary charge" means the amount the provider typically charges the general public for the product or service. For any given product, the amount charged by the pharmacy to fifty percent or more of its non-Medicaid clients shall be deemed its usual and customary charge.

(74) "Wholesaler" means a corporation, individual, or other entity which buys drugs or devices for resale and distributes the drugs or devices to corporations, individuals, or entities other than consumers.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1050, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1100 Covered drugs and pharmaceutical supplies. The department shall reimburse for:

(1) Outpatient legend drugs, generic or brand name, when the manufacturer has a signed rebate agreement with the federal Department of Health and Human Services, except as excluded under WAC 388-530-1150;

(2) Over-the-counter (OTC) drugs when the drug is:

(a) Prescribed;

(b) A less costly therapeutic alternative; and

(c) Formulary.

(3) Compounded prescriptions when billed by each formulary ingredient used in the compound;

(4) Nonformulary drugs when prior authorized by the department;

(5) Drug-related supplies;

(6) Family planning supplies used in conjunction with family planning under WAC 388-86-035, including OTC supplies. Covered family planning OTC supplies include, but are not limited to, hormonal contraceptives, spermicidal contraceptives and barrier contraceptives;

(7) Oral, topical and/or injectable drugs, vaccines for immunizations, and biologicals, prepared or packaged for

individual use and dispensed or administered to a client by an authorized provider;

(8) Obsolete national drug codes (NDCs) for up to two years from their date of obsolescence, as long as the drug is not a terminated drug product as defined in WAC 388-530-1050; and

(9) Drugs and supplies administered or provided under unusual and extenuating circumstances to clients by authorized providers who request and receive department approval. The secretary or secretary's designee shall review such requests on a case-by-case basis.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1100, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1150 Noncovered drugs and pharmaceutical supplies. The department shall not pay for:

(1) Noncontract drugs, brand or generic, when the manufacturer has not signed a rebate agreement with the federal Department of Health and Human Services, except as provided under WAC 388-530-1100(4) of this chapter;

(2) Covered outpatient drugs, biological products, insulin, supplies, appliances, and equipment included in other reimbursement methods, including, but not limited to:

- (a) Diagnosis-related group (DRG);
- (b) Ratio of cost to charges (RCC);
- (c) Nursing facility per diem;
- (d) Managed care capitation rates; and
- (e) Block grants.

(3) Any drug regularly supplied as an integral part of program activity by other public agencies;

(4) A drug when the drug is prescribed:

- (a) For weight loss or gain;
- (b) To promote fertility;
- (c) For cosmetic purposes or hair growth;
- (d) To promote smoking cessation; or

(e) For an indication which is not medically accepted as determined by MAA in consultation with federal guidelines, the Drug Utilization Education Council (DUEC), and MAA medical and pharmacy consultants.

(5) OTC drugs/supplies; unless approved for formulary use or family planning as described under WAC 388-86-035;

(6) Drugs listed in the federal register as "less-than-effective" ("DESI" drugs) or which are identical, similar, or related to such drugs;

(7) Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee;

(8) Prescription vitamins and mineral products in the absence of a condition that is clinically recognized to produce a deficiency state, except prenatal vitamins and fluoride preparations. Prenatal vitamins are covered only when prescribed and dispensed to pregnant women. Fluoride preparations are covered only for children, under the early and periodic screening, diagnosis, and treatment (EPSDT or "healthy kids") services;

(9) Drugs that are experimental, investigational, or of unproven efficacy or safety;

(10) Drugs requiring prior authorization for which department authorization has been denied;

(11) Preservatives, flavoring, and/or coloring agents used in the process of compounding;

(12) Less than a one-month supply of drugs for long-term therapy, except as provided under WAC 388-530-1250, Prior authorization. For a definition of long-term therapy, see WAC 388-530-1050(39);

(13) Prescriptions written on pre-signed prescription blanks filled out by nursing facility operators or pharmacists. The department shall terminate the core provider agreement of pharmacies involved in this practice;

(14) Drugs used to replace those taken from nursing facility emergency kits;

(15) Drugs used to replace a physician's stock supply;

(16) Free pharmaceutical samples;

(17) Obsolete NDCs, except that the department may allow reimbursement to a pharmacy for a drug product with an obsolete NDC when the product is dispensed to an eligible client not later than two years from the date the NDC is designated obsolete, if the drug is not a terminated drug product; and

(18) Terminated drug products.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1150, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1200 Drug formulary. (1) The medical assistance administration (MAA) shall not require prior approval for drug preparations listed in the MAA drug formulary for the initial prescription.

(a) MAA shall apply certain setting restrictions, such as nursing home or home use only as well as limits on quantity.

(b) MAA shall update the formulary list as necessary and shall publish the list periodically.

(2) To request inclusion of a drug product in MAA's drug formulary, a drug manufacturer shall send to the pharmacist consultant a written request and the following supporting documentation:

(a) Background data about the drug as requested by MAA;

(b) Product package information as requested by MAA;

(c) Any pertinent clinical studies; and

(d) Any additional information the manufacturer feels appropriate.

(3) MAA's pharmacist consultants and an advisory board shall evaluate drugs for formulary inclusion. The consultants and board may include MAA's medical consultants, the drug utilization and education council (DUEC), and/or participating MAA pharmacy providers.

(4) The criteria for evaluating whether to include or exclude a drug from MAA's formulary include, but are not limited to the following:

(a) The manufacturer has signed a federal drug rebate contract agreement;

(b) Like drugs are already on the formulary;

(c) The drug is a less-than-effective drug, or is identical, similar, or related to a less-than-effective drug;

(d) The drug falls into one of the categories authorized by federal law to be excluded from coverage;

(e) There are already less costly therapeutic alternatives in the formulary; and

(f) The drug has a potential for abuse.

(5) The MAA shall determine whether a drug should be covered with or without restrictions in a manner similar to how formulary status is determined.

(6) The department shall ensure decisions made in subsections (3) and (5) of this section are subject to review by the MAA assistant secretary or his/her designee. Manufacturers may seek review of adverse decisions by writing to the medical director.

(7) The department may require double blind drug studies to be performed when there is a question of medical necessity or efficacy and the medical literature on the issue is inconclusive. MAA may use the double blind study when:

- (a) Considering addition or deletion of a drug to the formulary;
- (b) Evaluating the relative merits of two drugs for general use or for a specific individual;
- (c) Evaluating requests for prior authorization; or
- (d) For whatever purpose the department deems necessary.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1200, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1250 Prior authorization. (1) Nonformulary drugs shall require prior authorization.

(2) MAA shall not require pharmacies to obtain prior authorization for formulary drugs, except for:

- (a) Subsequent refills of certain drugs, as identified in the Prescription Drug Program Billing Instructions per client, per month;
- (b) Those drugs which have specific per-month dose or unit limits as identified in the prescription drug program billing instructions;
- (c) Drugs identified in the billing instructions as limited to nursing facility clients when prescribed to clients residing outside a nursing facility; and
- (d) Brand name and generic drugs:

- (i) Which have an established maximum allowable cost (MAC); and
- (ii) For which the prescriber requests reimbursement at estimated acquisition cost (EAC).

(3) The pharmacy shall make a request to the department for drugs requiring prior authorization before dispensing the drug, except as provided for in subsection (6) of this section. The pharmacy shall:

- (a) Ensure the request states the medical diagnosis and includes medical justification for the drug; and
- (b) Keep on file the medical justification communicated to the pharmacy by the prescriber.

(4) MAA shall evaluate a request for prior authorization based on, but not limited to, the following criteria:

- (a) As required under WAC 388-530-1000(1), 388-530-1150, and 388-501-0165;

(b) The drug is of moderate cost as determined by the department. MAA shall select the least costly of two or more preparations of equal effectiveness; and

(c) The drug is not experimental, investigational, or of unproven efficacy or safety.

(5) The department may authorize certain prescribed drugs through a process called "expedited prior authorization." (See WAC 388-530-1050(28), Definitions.) MAA

shall determine drugs authorized through expedited prior authorization are those for which the department has established specific utilization criteria to address its concerns over the drugs':

- (a) High cost;
- (b) Potential for clinical misuse;
- (c) Narrow therapeutic indication; or
- (d) Safety.

(6) The department may authorize reimbursement at the brand name estimated acquisition cost (EAC) for a brand name multiple-source drug that would have been reimbursed at the established upper limit for that multiple-source drug, if:

- (a) The pharmacist calls for prior authorization; and
- (b) The prescriber writes "dispense as written" on the prescription form, or certifies in the prescriber's own handwriting that a specific brand is "medically necessary" for a particular client; or

(c) The availability of generics in the marketplace is severely curtailed and the price disparity between the brand name EAC and the generic maximum allowable cost (MAC) is such that clients would be effectively denied the medication.

(7) The department may pay for drugs requiring prior authorization which are dispensed without prior authorization only when:

- (a) Given in an acute emergency;
- (b) The department receives justification within seventy-two hours excluding weekends and Washington state holidays; and
- (c) The department agrees with the justification and approves the request.

(8) The pharmacy shall obtain prior authorization from the department for any and all prescription fills in excess of the limits specified under WAC 388-530-1800, Requirements for pharmacy claim payment.

(9) The department shall ensure prior authorization:

- (a) Is limited to a decision of medical appropriateness for a drug; and
- (b) Shall not guarantee payment.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1250, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1300 General reimbursement methodology. (1) Where the department has not contracted for pharmacy services through competitive procurement, the department shall ensure total reimbursement for a prescription drug does not exceed the lowest of:

- (a) Estimated acquisition cost (EAC) plus a dispensing fee;
- (b) Maximum allowable cost (MAC) plus a dispensing fee; or
- (c) The provider's usual and customary charge to the non-Medicaid population.

(2) If the provider offers a discount, rebate, promotion or other incentive which directly relates to the reduction of the price of a prescription to the individual non-Medicaid customer, the provider shall similarly reduce its charge to the department for the prescription.

(3) The department shall choose the in-state pharmaceutical wholesalers used to set EAC and MAC.

(4) The department may solicit assistance from representative pharmacy providers in establishing MAC and/or EAC.

(5) If the product is given free to the public, the pharmacy shall not submit a claim to the department if the product is given to a medical assistance client. If the product is sold at a discount to the general public, the pharmacy shall ensure any claim to the department for that product shall reflect the discounted charge.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1300, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1350 Estimated acquisition cost methodology. The department shall determine estimated acquisition cost (EAC) as follows:

(1) Periodically, the department shall:

(a) Take a sample of, at minimum, two hundred fifty of the top national drug codes paid for by the MAA excluding drugs under the MAC program; and

(b) Determine pharmacies' average acquisition costs for these products.

(2) The department shall decide the sampling frequency of the top drug products by dollar volume under medical assistance to determine EAC, but the frequency shall not be:

(a) More than once every three years; and

(b) Less than once every ten years.

(3) The pharmacies' average acquisition cost for the products in the sample shall be based on in-state wholesalers' published prices to pharmacy subscribers, plus an average subscriber upcharge, if applicable.

(4) MAA shall express the average acquisition cost for each product on the sample list during the period under study as a percentage of the average wholesale price (AWP) determined for that product by the department's drug pricing file contractor.

(5) MAA shall average the percentages obtained for the sample, and the resulting percentage shall represent the estimated acquisition cost (EAC).

(6) MAA may base EAC on standard package size or the price of the actual package size dispensed.

(7) MAA may set EAC for specified drugs or drug categories at AWP percentages other than those determined in subsection (5) of this section when MAA deems it necessary. The department shall cease such exemption when the necessity no longer exists.

(8) The department shall pay at EAC the brand name and generic drugs with an MAC established if the EAC is lower than the MAC price.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1350, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1400 Maximum allowable cost methodology. (1) When the department determines there is a likelihood that a cost savings will result the department may establish a maximum allowable cost (MAC) for a multiple-source drug which is available from at least three manufacturers/labelers.

(2) The department may exclude from MAC selected multiple-source drugs when clinical response significantly differs between brand and generic equivalents.

[Title 388 WAC—p. 660]

(3) The department shall determine the MAC for a multiple-source drug by:

(a) Generating a manufacturers/labelers list for a multiple-source drug from data provided by the drug pricing file contractor;

(b) Ensure the list is arranged by cost, showing wholesalers' national actual acquisition cost (NAAC) for the drug from each manufacturer/labeler;

(c) If there is a Federal Upper Limit (FUL) for the multiple-source drug, the FUL shall be adopted, except, if the FUL is lower than the pharmacies' actual acquisition cost (AAC) for an available product based on information provided by representative pharmacy providers, a MAC shall be chosen in cooperation with the representative pharmacy providers. The chosen fee shall be the lowest amount sufficient to cover in-state pharmacies' AAC based on information provided by the representative pharmacy providers;

(d) Establish estimated acquisition cost (EAC) of the third lowest priced product as the recommend MAC, except:

(i) If the MAC established is lower than pharmacies' AAC for the three lowest priced products, based on information provided by the representative pharmacy providers, a MAC shall be chosen in cooperation with the representative pharmacy providers. The chosen fee shall be the lowest amount sufficient to cover in-state pharmacies' average acquisition cost based on information provided by the representative pharmacy providers; or

(ii) A MAC may be established for a drug using the maximum allowable cost set by another third party for that drug.

(4) The MAC established for a multiple-source drug shall not apply if the prescriber certifies that a specific brand is "medically necessary" for a particular client. In such cases EAC shall apply, provided prior authorization is obtained from MAA as specified under WAC 388-530-1250 (6)(a), Prior authorization.

(5) The department shall pay the EAC for a multiple-source product if the EAC for a multiple-source product is less than the MAC established for that product.

(6) Automated maximum allowable cost (AMAC) pricing shall apply to multiple-source drugs:

(a) Not identified under subsection (2) of this section;

(b) Produced by three or more manufacturers/labelers under federal drug rebate agreement; and

(c) Which are not on the MAC list.

(7) AMAC reimbursement for all products within a generic code number (GCN) sequence shall be at the EAC of the third lowest priced product in that sequence, or the EAC of the lowest priced drug under a federal rebate agreement in that sequence, whichever is higher.

(8) If the established AMAC price exceeds the FUL, the department shall set the price at the FUL.

(9) The department shall pay the estimated acquisition cost (EAC) for a multiple-source product if the EAC for a multiple-source product is less than the AMAC established for that product.

(10) MAA shall recalculate AMAC each time there are pricing updates provided by the drug file contractor to any product in GCN sequences covered under the AMAC program.

(11) The department shall ensure the maximum payment for multiple-source drugs for which HCFA has set a FUL

does not exceed, in the aggregate, the prescribed upper limits plus the dispensing fees set by the department.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1400, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1450 Dispensing fee determination. Subject to the provisions of WAC 388-530-1300, MAA shall pay a dispensing fee for each covered prescription.

(1) The department shall adjust the dispensing fee by weighing factors including, but not limited to:

(a) Legislative appropriations for vendor rates;
(b) Input from provider and/or advocacy groups;
(c) Input from state-employed or contracted actuaries; and

(d) Dispensing fees paid by other third-party payers, including but not limited to health care plans and other states' Medicaid agencies.

(2) The MAA shall use a tiered dispensing fee system which reimburses large volume pharmacies at a lower fee and small volume pharmacies at a larger fee. In MAA's judgment such a system best preserves or enhances clients' access to services by promoting equitable payment to pharmacy providers.

(3) In a tiered dispensing fee system, the MAA shall use total annual prescription volume (both Medicaid and non-Medicaid) reported to the department to determine each pharmacy's dispensing fee category.

(a) A pharmacy which fills thirty-five thousand and one or more prescriptions annually shall be a high-volume pharmacy.

(b) A pharmacy which fills between fifteen thousand and one and thirty-five thousand prescriptions annually shall be a mid-volume pharmacy.

(c) A pharmacy which fills fifteen thousand or fewer prescriptions annually shall be a low-volume pharmacy.

(4) The department shall determine a pharmacy's annual total prescription volume as follows:

(a) The department shall send out a prescription volume survey form to pharmacy providers during the first quarter of the calendar year;

(b) Pharmacies shall return completed prescription volume surveys to the department by the date specified by the department each year. The department shall assign providers not responding to the survey by the specified date to the high volume category;

(c) Pharmacies shall:

(i) Include all prescriptions dispensed from the same physical location in the pharmacy's total prescription count; and

(ii) Report totals from the same location to the department on the same form. Hospital-based pharmacies which serve both inpatient and outpatient clients shall not include hospital inpatient doses/prescriptions in the total volume reported to the department. The department shall deem prescriptions dispensed to nursing facility clients outpatient prescriptions;

(d) If a pharmacy uses more than one provider number to bill MAA for pharmacy claims dispensed from the same physical location, the pharmacy shall list on one form all of

the provider numbers contributing to the total volume being reported;

(e) Reassignment to current or assignment to new dispensing fee categories shall be effective on the first of the month following the date specified by the department for receipt of completed prescription volume survey forms.

(5) In a tiered dispensing fee system, a pharmacy may request a change to a lower volume category during the interval between the annual prescription volume surveys. The pharmacy shall support such a request with documentation showing that the pharmacy's most recent six-month dispensing data, annualized, would qualify the pharmacy for a lower volume category.

(6) MAA may adopt a uniform dispensing fee if in its judgment such a system would best preserve or enhance clients' access to services by promoting equitable payment to pharmacy providers.

(7) The department shall grant general dispensing fee rate increases only when authorized by the legislature. Amounts authorized for dispensing fee increases may be distributed nonuniformly (e.g., tiered dispensing fee based upon volume), if necessary, to ensure client access.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1450, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1500 Reimbursement for compounded prescriptions. (1) Notwithstanding the definition in WAC 388-530-1050(7), the department shall not consider reconstitution to be compounding.

(a) The department may consider the adjustment of therapeutic strengths and/or forms by a pharmacist in the preparation of a prescription to be compounding if the client's drug therapy needs are unable to be met by commercially available dosage strengths and/or forms of the medically necessary drug.

(b) The pharmacist shall ensure the need for the adjustment of the drug's therapeutic strength and/or form is well documented in the client's file.

(2) Compounded prescriptions shall be reimbursed as follows:

(a) The department shall allow only the lowest cost for each formulary ingredient. EAC, MAC, or amount billed shall apply.

(b) The department shall apply current prior authorization requirements to drugs used as ingredients in compounded prescriptions, except as provided under subsection (2)(c) of this section. MAA shall deny payment for a drug requiring prior authorization used:

(i) As an ingredient in a compounded prescription; but
(ii) For which prior authorization was not obtained.

(c) The department may designate selected drugs as not requiring prior authorization when used for compounded prescriptions, but requiring prior authorization for other uses. The department shall publish such lists periodically.

(d) The department shall give:

(i) Each formulary or prior authorized drug ingredient billed separately a dispensing fee set by the department as described under WAC 388-530-1450; and

(ii) Drugs used in compounding under subsection (2)(c) of this section a dispensing fee set by the department as described under WAC 388-530-1450.

(e) MAA shall not pay a separate fee for compounding time. MAA shall replace the fee for compounding time with a dispensing fee for each ingredient, as described under WAC 388-530-1450.

(3) In addition to reimbursement for ingredient and dispensing fees, MAA shall set maximum allowable fees for special procedures, equipment, or supplies used in compounding prescriptions. MAA shall call these fees compounded prescription preparation fees.

(a) The pharmacy shall note in its records any necessary special procedures, equipment or supplies, or containers used in preparing the compounded prescription.

(b) MAA shall adjust compounded prescription preparation fees by taking into account factors including, but not limited to:

(i) Legislative appropriations for vendor rates;

(ii) Input from provider and/or advocacy groups;

(iii) Audit findings regarding costs of compounding equipment and supplies, as specified in subsection (5) of this section; and

(iv) Compounded prescription preparation fees paid by other third-party payers, including but not limited to health care plans and other states' Medicaid agencies.

(c) MAA shall not reimburse compounded prescription preparation fees for infusion productions; MAA reimbursement for home infusion and other intravenous admixtures shall be for ingredient costs and dispensing fees only.

(d) MAA shall reimburse pharmacies for only one preparation fee for each compounded prescription.

(e) Pharmacies shall bill MAA for compounded prescription preparation fees using state-assigned drug codes, which MAA shall publish periodically.

(f) MAA shall ensure a separate dispensing fee does not apply to preparation fee codes.

(4) MAA shall periodically sample ten percent of pharmacy claims for compounded drugs. The MAA pharmacist consultant shall review these claims to determine if the drugs were appropriately dispensed in compounded form, or if less costly equivalent alternative preparations were already available commercially. If MAA finds that a pharmacy provider is inappropriately compounding or billing for compounded drugs, MAA shall take whatever corrective action it deems necessary, including but not limited to:

(a) Education of the provider regarding the problem practice(s);

(b) Recoupment of payment for the compounded drug, or the differential between the compounded form and its commercially available, less costly alternative form; and/or

(c) Termination of the provider's core provider agreement in extreme cases.

(5) MAA may audit selected pharmacies dispensing compounded prescriptions to determine acquisition or estimated costs of equipment and/or supplies used in compounding.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1500, filed 10/9/96, effective 11/9/96.]

[Title 388 WAC—p. 662]

WAC 388-530-1550 Unit dose drug delivery systems.

(1) The department shall pay for unit dose drug delivery systems only for clients residing in nursing facilities, except as provided in subsections (6) and (7) of this section.

(2) The department shall pay pharmacies that provide true unit dose delivery service the department's highest allowable dispensing fee for each prescription dispensed to clients in nursing facilities. The department shall reimburse ingredient costs for drugs under true unit dose systems at the appropriate MAC or EAC. The department shall pay true unit dose providers for drugs dispensed in manufacturers' unit dose packaging at the EAC for the specific unit dose NDCs.

(3) The department shall pay modified unit dose pharmacies the department's highest allowable dispensing fee for repackaged bulk drugs dispensed in unit dose form to clients in nursing facilities. The department shall reimburse ingredient costs for bulk drugs repackaged into unit dose form at the lesser of MAC or EAC. The department shall deem creams, ointments, ophthalmic/otic preparations, and other liquids as not deliverable in this packaging system.

(4) MAA shall pay a pharmacy that dispenses drugs in bulk containers or multi-dose form to clients in nursing facilities the regular dispensing fee applicable to the pharmacy's total annual prescription volume category. Drugs not deliverable in unit dose form include, but are not limited to, oral liquids, creams, ointments, ophthalmic and otic solutions. The department shall reimburse ingredient costs for such drugs at the lesser of MAC or EAC.

(5) MAA shall pay a pharmacy that dispenses drugs prepackaged by the manufacturer in unit dose form to clients in nursing facilities the regular dispensing fee applicable to that pharmacy's total annual prescription volume category. The department shall pay ingredient costs at the EAC applicable to the unit dose national drug code (NDC).

(6) MAA shall pay for manufacturer-designated unit dose drugs dispensed to clients not residing in nursing facilities when such drugs:

(a) Are available in the marketplace only in manufacturer-designated unit dose packaging; and

(b) Would otherwise have been covered outpatient drugs. The unit dose dispensing fee shall not apply in such cases. The pharmacy shall be paid the dispensing fee applicable to the pharmacy's total annual prescription volume category.

(7) MAA may pay for modified unit dose delivery systems for developmentally disabled (DD) clients residing in approved community living arrangements.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1550, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1600 Unit dose pharmacy billing requirements. (1) To be eligible for a unit dose dispensing fee, a pharmacy shall:

(a) Notify MAA in writing of its intent to provide unit dose service;

(b) Specify the type of unit dose service to be provided;

(c) Identify the nursing facility to be served;

(d) Indicate the approximate date unit dose service to the facility will commence; and

(e) Sign an agreement to follow department requirements for unit dose reimbursement.

(2) Under a true or modified unit dose delivery system, a pharmacy may bill MAA for the number of drug units dispensed.

(3) The pharmacy shall submit an adjustment form or claims reversal of the charge to MAA for the cost of unused drugs returned to the pharmacy on or before the sixtieth day following the date the drug was dispensed, except as provided in subsection (4) of this section. Such adjustment shall conform to the nursing facility's monthly log as described in subsection (6).

(4) Modified unit dose providers do not have to credit MAA for controlled substances which are returned to the pharmacy.

(5) Pharmacies shall not charge clients or MAA a fee for repackaging a client's bulk medications in unit dose form. The costs of repackaging shall be the responsibility of the nursing facility when the repackaging is done:

(a) To conform with a nursing facility's delivery system; or

(b) For the nursing facility's convenience.

(6) The pharmacy shall maintain detailed records of medications dispensed under unit dose delivery systems. The pharmacy shall keep a monthly log for each nursing facility served, including but not limited to the following information:

(a) Facility name and address;

(b) Client's name and patient identification code (PIC);

(c) Drug name/strength;

(d) NDC or labeler information;

(e) Quantity and date dispensed;

(f) Quantity and date returned;

(g) Value of returned drugs or amount credited;

(h) Explanation for no credit given or nonreusable returns; and

(i) Prescription number.

(7) Upon MAA's request, the pharmacy shall submit copies of the logs referred to in subsection (6) on a monthly, quarterly, or annual basis.

(8) The pharmacy shall submit annually with the completed prescription volume survey to MAA:

(a) An updated list of nursing facilities served under unit dose systems; and

(b) The nursing facilities' respective billing period start dates.

[Statutory Authority: RCW 74.04.050, 74.08.090, 42 CFR 447.333 and Attachment 4.19-B, Page 2-b of the State Plan under Title XIX of the Social Security Act. 98-14-005, § 388-530-1600, filed 6/18/98, effective 7/19/98. Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1600, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1650 Reimbursement for pharmaceutical supplies. (1) The medical assistance administration (MAA) shall pay for covered pharmaceutical supplies not already included in other payment systems.

(2) MAA shall base reimbursement of pharmaceutical supplies on MAA-published fee schedules.

(3) MAA shall use any or all of the following methodologies to set the maximum allowable for a pharmaceutical device/supply:

(1999 Ed.)

(a) Provider's acquisition cost. Upon review of the claim, MAA may require an invoice;

(b) Medicare's reimbursement for the item; or

(c) A specified discount off the item's list price or manufacturer's suggested retail price (MSRP).

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1650, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1700 Drugs and pharmaceutical supplies from nonpharmacy providers. (1) The medical assistance administration (MAA) shall pay for covered drugs and supplies dispensed or administered by nonpharmacy providers under specified conditions.

(2) MAA may pay actual acquisition cost (AAC) to a physician or ARNP for a covered drug (oral, topical or injectable) prepared or packaged for individual use and dispensed or administered to a client during an office visit. When the cost of the drug dispensed or administered to the patient exceeds the established fee, the physician may submit to MAA a photocopy of the invoice for the actual drug cost. The invoice shall show the name of the drug manufacturer, drug strength, and dosage.

(3) MAA shall not reimburse providers for the cost of vaccines obtained by the provider through the state department of health. However, MAA shall pay the provider a set fee established at twenty to thirty-five percent of the fee for a brief office visit for administering the vaccine.

(4) MAA may pay AAC to family planning clinics for birth control pills and contraceptive supplies the clinics distribute to clients. MAA may request an invoice for the actual cost of the drug. If an invoice is requested, the clinic shall ensure the invoice shows the name of the drug manufacturer, drug strength, and dosage.

(5) MAA shall determine drugs and supplies provided to clients by local health departments are reimbursed according to MAA's established fee schedules.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1700, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1750 Drugs and pharmaceutical supplies for clients with any third-party coverage. (1) Except as specified under contract, MAA shall not reimburse providers for any drugs/supplies provided to clients who have pharmacy benefits under managed care plans. The managed care plan shall be responsible for payment.

(2) For the purposes of the section, the following definitions apply:

(a) "Closed pharmacy network" means an arrangement made by an insurer which restricts prescription coverage to an exclusive list of pharmacies. This arrangement prohibits the coverage and/or payment of prescriptions provided by a pharmacy not included on the exclusive list.

(b) "Private point-of-sale (POS) authorization system" means an insurer's system, other than the MAA POS system, which requires that coverage be verified or submitted for authorization by the insurer's agent at the time of service and at the time the prescription is filled.

(3) MAA clients who have a third-party resource which is a managed care entity or other insurance requiring the use of "closed pharmacy networks" or "private point-of-sale

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authorization systems" shall not have prescription provider claims paid until the prescription provider submits an explanation of benefits from the private insurance which demonstrates that the prescription provider has complied with the terms of coverage. If the private insurer has paid:

(a) A fee based on the incident of care, the prescription provider shall file a claim with the department consistent with the department's billing requirements; or

(b) The prescription provider a monthly capitation fee for all prescription costs related to the client, the prescription provider may submit a claim to the department for the amount of the client co-payment, co-insurance, and/or deductible. The department shall pay the provider:

(i) The lesser of the billed amount; or

(ii) The department's maximum allowable fee for the prescription.

(4) For clients eligible for both Medicare and Medicaid, providers shall:

(a) Be reimbursed for drugs not covered by Medicare, but covered by MAA;

(b) Not be reimbursed for drugs covered by Medicare.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1750, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1800 Requirements for pharmacy claim payment. (1) Pharmacies shall:

(a) Use the appropriate department claim form or electronic billing specifications when billing for pharmacy services; and

(b) Complete such forms or billings before submitting claims to MAA. Complete forms shall include the actual eleven-digit NDC number of products dispensed.

(2) To bill drugs requiring authorization, providers shall insert the authorization number in the appropriate data field of the drug claim.

(3) To bill drugs under the expedited authorization process, providers shall insert the authorization number and criteria codes in the appropriate data field of the drug claim.

(4) Pharmacy services for clients on restriction under WAC 388-501-0135 shall be prescribed by the client's primary provider and payable only to the client's primary pharmacy, except in cases of emergency, family planning, or properly referred services.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1800, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1850 Drug utilization and education council. MAA shall establish a DUR board, called the drug utilization and education council. The DUR board shall:

(1) Have a minimum of eight and a maximum of ten members, representing the state professional associations of medicine, pharmacy, and nursing. The board shall:

(a) Be made up of at least one-third but not more than fifty-one percent physicians, and at least one-third but not more than fifty-one percent pharmacists; and

(b) Include an advanced registered nurse practitioner and a physician's assistant. The department shall determine membership rotation.

(2) Meet periodically to:

(a) Advise the department on DUR activities;

- (b) Review provider and patient profiles;
- (c) Recommend adoption of standards and treatment guidelines for drug therapy;
- (d) Provide interventions targeted toward therapy problems; and
- (e) Produce an annual report.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1850, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1900 Drug use review. The department shall provide for a drug use review (DUR) program consisting of:

(1) Prospective drug use review (Pro-DUR), wherein all prescription drug providers shall:

(a) Obtain a patient history;

(b) Screen for potential drug therapy problems; and

(c) Counsel the patient in accordance with existing state pharmacy laws and federal regulations.

(2) Retrospective drug use review (Retro-DUR), wherein the department shall provide for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and individuals receiving benefits.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-1900, filed 10/9/96, effective 11/9/96.]

WAC 388-530-1950 Point-of-sale (POS) system/prospective drug utilization review (Pro-DUR). (1) Pharmacy claims processed through the medical assistance administration (MAA) payment system shall be adjudicated by the MAA point-of-sale (POS) system. This includes claims received on-line, via paper or by modem, disk, or tape.

(2) MAA shall ensure claims processed through the POS system undergo a system-facilitated prospective drug utilization review (Pro-DUR) screening. The system-facilitated Pro-DUR screening shall be performed by the MAA POS computer system at the time a drug claim is received and shall be intended as a complement to the Pro-DUR screening required of pharmacists.

(3) For the purposes of this section, the following definition applies: "MAA-approved national council for prescription data processing (NCPDP) codes" means those NCPDP codes appearing in the MAA prescription drug program billing instructions which MAA has approved for use in overriding MAA POS system alert messages.

(4) If the MAA POS/Pro-DUR system identifies a potential drug therapy problem during system-facilitated Pro-DUR screening, MAA may deny the claim with an alert message indicating the type of potential problem, including but not limited to:

- (a) Therapeutic duplication;
- (b) Duration of therapy exceeds maximum;
- (c) Serious drug-to-drug interaction;
- (d) Overdosage;
- (e) Ingredient duplication;
- (f) Drug age conflict; or
- (g) Refill too soon.

(5) MAA may deny claims:

(a) Which trigger an alert message in the POS system; or

(b) For drugs for which the department has established specific utilization criteria to address MAA concerns over the drug's high cost, potential for clinical misuse, narrow therapeutic indication or safety:

(i) For which prior authorization has not been received; or

(ii) Which do not include an appropriate MAA-approved expedited prior authorization code or MAA-approved NCPDP code.

(6) If the MAA POS/Pro-DUR system identifies a potential drug therapy problem as described in subsection (4) of this section and the claim is denied for this reason, the dispensing pharmacist shall attempt to resolve the issue through professional utilization review. If upon further investigation a therapy problem is found not to exist, the pharmacist may dispense the drug product and:

(a) Request MAA authorization for payment as specified in WAC 388-530-1250, prior authorization; or

(b) Resubmit the claim using an applicable MAA-approved NCPDP override code as listed in the prescription drug program billing instructions.

(7) The department shall determine POS/Pro-DUR screening is not applicable to pharmacy claims included in the managed care capitated rate.

[Statutory Authority: RCW 74.08.090. 96-08-018 (Order 3960), § 388-530-1950, filed 3/26/96, effective 4/26/96.]

WAC 388-530-2050 Out-of-state prescriptions. (1) The department shall reimburse out-of-state pharmacies for drugs provided to Washington state residents who are temporarily located outside the state subject to the provisions of WAC 388-501-0180.

(2) Border situations as described under WAC 388-501-0175 are not subject to out-of-state rules, and the department shall consider pharmacies in border areas to be providers in the state of Washington.

(3) Out-of-state pharmacies shall meet the same criteria for payment as in-state pharmacies.

[Statutory Authority: RCW 74.08.090. 96-21-031, § 388-530-2050, filed 10/9/96, effective 11/9/96.]

Chapter 388-535 WAC DENTAL-RELATED SERVICES

WAC

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WAC 388-535-1000 Dental-related services—Scope of coverage. (1) The medical assistance administration (MAA) shall pay only for covered medical and dental services, equipment, and supplies listed in MAA published issu-

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ances, including billing instructions, numbered memoranda, and bulletins.

(2) MAA shall pay for covered dental services, equipment and supplies when they are:

(a) Within the scope of an eligible client's medical care program;

(b) Medically necessary;

(c) Within accepted medical or dental practice standards and are:

(i) Consistent with a diagnosis; and

(ii) Reasonable in amount and duration of care, treatment, or service.

(d) Not noncovered services as described under WAC 388-535-1100, Noncovered dental services; and

(e) Billed according to the conditions of payment under WAC 388-87-010 and 388-87-015.

(3) MAA shall cover the following dental-related services:

(a) Oral health evaluations/assessments, including oral health screening by providers of early and periodic screening, diagnoses and treatment (EPSDT) screening services authorized by MAA to provide screening.

(i) Oral health evaluation or assessment services shall be covered every six months, and an oral health evaluation of a child shall include an indicator of the child's oral health status.

(ii) The screening services shall, at a minimum, include:

(A) A comprehensive oral health and developmental history;

(B) An assessment of physical and oral health development and nutritional status;

(C) Health education, including anticipatory guidance; and

(D) Oral health status.

(b) Dental services necessary for the identification of dental problems or the prevention of dental disease subject to limitations of this chapter;

(c) Coronal polishing and scaling, provided that coronal polishing shall not be covered for children seven years old or younger, unless prior authorized, see WAC 388-535-1200 (1)(e);

(d) Dental services or treatment necessary for the relief of pain and infections, including removal of wisdom teeth, except that routine removal of wisdom teeth without justifiable medical indications shall not be covered;

(e) Dental services or treatment necessary for the restoration of teeth and maintenance of dental health subject to limitations of this chapter;

(f) Orthodontic treatment, which is defined as the use of any appliance, intraoral or extraoral, removable or fixed, or any surgical procedure designed to move teeth. The following limitations apply:

(i) Orthodontic coverage is limited to clients who are eligible for the EPSDT/healthy kids services;

(ii) Prior approval is required; and

(iii) Treatment is limited to conditions specified in WAC 388-535-1250.

(g) Complete and partial dentures, and necessary modifications, repairs, rebasing, relining and adjustments of den-

tures. Cast base partial dentures are covered with prior authorization.

(4) For children identified as high risk through oral health evaluation/assessment or clients identified by the department as developmentally disabled, the following preventive services may be allowed more frequently than the limits listed in (3) of this section:

(a) Fluoride application;

(b) Root planing, if a developmentally disabled client; and

(c) Prophylaxis scaling and coronal polishing, if eight years of age and over, or developmentally disabled.

(5) Panoramic radiographs are allowed only for oral surgical or orthodontic purposes.

(6) The department shall cover medically necessary services provided in a hospital for the care or treatment of teeth, jaws, or structures directly supporting the teeth if the procedure requires hospitalization. Services covered under this subsection shall be furnished under the direction of a physician or dentist.

(7) For clients residing in nursing facilities or group homes, the following additional requirements shall apply:

(a) Dental services shall be requested by the client or a referral for services made by the attending physician, facility nursing supervisor, or the client's legal guardian;

(b) Mass screening for dental services of clients residing in a facility is not permitted, except for the EPSDT/healthy kids services as described under WAC 388-86-027;

(c) Nursing facilities shall provide medically necessary dental services in accordance with WAC 388-97-225.

(8) If eligibility for dental services ends before the conclusion of the dental treatment, payment for any remaining treatment shall be the client's responsibility. The client shall be responsible for payment of any dental treatment or service received during any period of ineligibility for medical care, even if the treatment was started when the client was eligible.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1000, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1050 Definitions. This section contains definitions of words and phrases the department uses in rules for the medical assistance administration dental program.

(1) "**Access to baby and child dentistry (ABCD)**" is a Spokane County pilot initiative to increase access to dental services for Medicaid eligible infants, toddlers, and preschoolers.

(2) "**Arch**" means the curving structure formed by the crowns of the teeth in their normal position, or by the residual ridge after loss of the teeth.

(3) "**Banding**" means the application of orthodontic brackets to the teeth and/or face for the purpose of correcting dentofacial abnormalities.

(4) "**Behavior management**" means managing the behavior of a client during treatment using the assistance of additional professional staff, and restraints such as a papoose board or sedative agent, to protect the client from self-injury.

(5) "**Buccal**" means pertaining to or directed toward the cheek.

(6) "**By report**" - a method of payment for a covered service, supply, or equipment for which the medical assis-

tance administration has not established a maximum allowable, either because the service or supply is new and its use is not yet considered standard, or it is a variation on a standard practice, or is rarely provided. Payment for a "by report" service or item is made on a case-by-case basis.

(7) "**Caries**" means a disease of the calcified tissues of the teeth resulting from the action of microorganisms on carbohydrates, characterized by a decalcification of the inorganic portion of the tooth and accompanied or followed by disintegration of the organic portion.

(8) "**Child**" - for purposes of the dental program, a child is defined as a person zero through eighteen years of age.

(9) "**Cleft**" means a longitudinal opening or fissure, especially one occurring in the embryo. Also see "facial cleft."

(10) "**Comprehensive oral evaluation**" means a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. Includes the evaluation and recording of the patient's dental and medical history and a general health assessment.

(11) "**Corona**" is the portion of a tooth that is covered by enamel, and is separated from the root or roots by a slightly constricted region, known as the neck.

(12) "**Craniofacial anomalies**" means abnormalities of the head and face, either congenital or acquired.

(13) "**Current dental terminology (CDT), second edition (CDT-2)**," a systematic listing of descriptive terms and identifying codes for reporting dental services and procedures performed by dental practitioners. CDT is published by the Council on Dental Benefit Programs of the American Dental Association (ADA).

(14) "**Dental analgesia**" means the use of agents to induce insensibility to or relief from dental pain without loss of consciousness.

(15) "**Dental anesthesia**" means the use of agents to induce loss of feeling or sensation in order to allow dental services to be rendered to the client. The term is applied especially to the loss of sensation of pain through general anesthesia.

(16) "**Dentin**" is the chief substance or tissue of the teeth, which surrounds the tooth pulp and is covered by enamel on the crown and by cementum on the roots of the teeth.

(17) "**Dental prosthesis**" means a replacement for one or more of the teeth or other oral structure, ranging from a single tooth to a complete denture.

(18) "**Dentures**" are a set of natural or artificial teeth; ordinarily used to designate an artificial replacement for the natural teeth.

(19) "**Dysplasia**" means an abnormality of development of the teeth.

(20) "**Enamel**" is the white, compact, and very hard substance that covers and protects the dentin of the crown of a tooth.

(21) "**Facial clefts**" are the clefts between the embryonic processes which normally unite to form the face. Failure of such union, depending on its site, causes such developmental defects as cleft lip (harelip), cleft mandible, oblique facial cleft, and transverse facial cleft (macrostomia).

(22) "**High risk**" child means any child who has been identified through an oral evaluation or assessment as having a high risk for dental disease because of caries in the child's dentin; or a child identified by the department as developmentally disabled.

(23) "**Hypoplasia**" means the incomplete or defective development of the enamel of the teeth.

(24) "**Limited oral evaluation**" means an evaluation or reevaluation limited to a specific oral health situation or problem.

(25) "**Limited visual oral assessment**" - A service performed by dentists which involves assessing the need for sealants to be placed by dental hygienists; screening children in Head Start or ECEAP programs; providing triage services; or in circumstances referring a child to another dentist for treatment. These assessments are also used by dental hygienists performing intraoral screening of soft and hard tissues to assess the need for prophylaxis, sealants, fluoride varnish, or refers to a dentist for other dental treatment.

(26) "**Low risk**" child means any child who has been identified through an oral evaluation or assessment as having a low risk for dental disease because of the absence of white spots or caries in the enamel or dentin. This category includes children with restorations who are otherwise without disease.

(27) "**Macrostomia**" means a greatly exaggerated width of the mouth, resulting from failure of union of the maxillary and mandibular processes, with extension of the oral orifice to the ear. The defect may be unilateral or bilateral.

(28) "**Malocclusion**" means the contact between the maxillary and mandibular teeth as will interfere with the highest efficiency during the excursive movements of the jaw that are essential to mastication. The abnormality is categorized into four classes, graded by angle.

(29) "**Moderate risk**" child means a child who has been identified through an oral evaluation or assessment as having a moderate risk for dental disease, based on presence of white spots, enamel caries or hypoplasia.

(30) "**Occlusion**" means the relation of the maxillary and mandibular teeth when in functional contact during activity of the mandible.

(31) "**Oral evaluation**" is an evaluation performed on a client, new or established, to determine the patient's dental and/or medical health status, or changes to that status.

(32) "**Oral health assessment or screening**" is a comprehensive oral health and developmental history; an assessment of physical and oral health development and nutritional status; and health education, including anticipatory guidance.

(33) "**Oral health status**" refers to the client's risk or susceptibility to dental disease at the time an oral evaluation is done by a dental practitioner. This risk is designated as low, moderate or high based on the presence or absence of certain indicators.

(34) "**Oral sedation**" means the use of oral agents to produce a sedative or calming effect.

(35) "**Orthodontia**" is a treatment involving the use of any appliance, intraoral or extraoral, removable or fixed, or any surgical procedure designed to move teeth.

(35) "**Partial dentures**" means a prosthetic appliance replacing one or more missing teeth in one jaw, and receiving

its support and retention from both the underlying tissues and some or all of the remaining teeth.

(36) "**Prophylaxis**" is a preventive intervention which includes the scaling and polishing of teeth to remove coronal plaque, calculus, and stains.

(37) "**Rebase**" means to replace the base material of a denture without changing the occlusal relations of the teeth.

(38) "**Reline**" means to resurface the tissue side of a denture with new base material in order to achieve a more accurate fit.

(39) "**Restorative services**" means services or treatments to restore a tooth to its original condition by the filling of a cavity and replacement of lost parts, or the material used in such a procedure.

(40) "**Root planing**" is a procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased cementum or dentin from the teeth's root surfaces and pockets.

(41) "**Scaling**" means the removal of calculous material from the exposed tooth surfaces and that part of the teeth covered by the marginal gingiva.

(42) "**Sealant**" is a material applied to teeth to prevent dental caries.

(43) "**Space management therapy**" is a treatment to hold space for missing first and/or second primary molars and maintain position for permanent teeth.

(44) "**Usual and customary charge**" means the fee that the provider usually charges his or her non-Medicaid customers for a service or item. This is the maximum amount that the provider may bill MAA for the same service or item.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1050, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1100 Noncovered dental services. (1) Unless required as a result of a EPSDT/Healthy Kids screen, included as part of a managed care plan service package; included in a waivered program; or part of one of the Medicare programs for the qualified Medicare beneficiaries; the MAA may exclude from the scope of covered dental-related services:

(a) Services, procedures, treatment, devices, drugs, or application of associated services which MAA or the Health Care Financing Administration (HCFA) consider investigative or experimental on the date the services are provided;

(b) Cosmetic treatment or surgery, except for medically necessary reconstructive surgery to correct defects attributable to an accident, birth defect, or illness;

(c) Orthodontia for adults, except that Medicaid eligible clients nineteen and twenty years of age who meet the criteria in WAC 388-535-1250 shall be covered;

(d) Orthodontia for children who do not meet the criteria in WAC 388-535-1250, or who request orthodontia for cosmetic reasons;

(e) Any service specifically excluded by statute;

(f) More costly services when less costly equally effective services as determined by the department are available;

(g) Nonmedical equipment, supplies, personal or comfort items and/or services;

(h) Prophylaxis, for children seven years of age or younger, unless developmentally disabled;

(i) Root planing for children eighteen years of age or younger;

(j) Molar endodontics for clients nineteen years of age or older;

(k) Endodontic services for anterior primary teeth, except that new therapeutic pulpotomy shall be covered; and

(l) For a persons nineteen years of age and older, unless developmentally disabled:

- (i) Routine fluoride treatments;
- (ii) Molar endodontics; or
- (iii) Orthognathic surgery.

(2) MAA does not pay for the following services/supplies:

- (a) Missed or canceled appointments;
- (b) Provider mileage or travel costs;
- (c) Take-home drugs;
- (d) Dental supplies such as toothbrushes, manual or automatic, electric, toothpaste, floss, or whiteners;
- (e) Educational supplies;
- (f) Reports, client charts, insurance forms, copying expenses;
- (g) Service charges/delinquent payment fees;
- (h) Dentists writing prescriptions or calling in prescriptions or prescription refills to a pharmacy; and

(i) Medical supplies used in conjunction with an office visit.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1100, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1150 Eligible dental providers defined. (1) The following providers shall be eligible for enrollment to provide and be reimbursed for dental-related medical services to eligible clients:

(a) Persons currently licensed by the state of Washington to practice medicine and osteopathy, for oral surgery procedures;

(b) Persons currently licensed by the state of Washington to practice dentistry;

(c) Persons currently licensed by the state of Washington to practice as dental hygienists;

(d) Persons currently licensed by the state of Washington to provide denture services (denturists);

(e) Hospitals currently licensed by the department of health;

(f) Federally-qualified health centers;

(g) Participating health departments;

(h) Medicare-certified ambulatory surgical centers;

(i) Medicare-certified rural health clinics;

(j) Public health providers of dental screening services who have a signed agreement with the department to provide such services to persons eligible for EPSDT/healthy kids services; and

(k) Border area or out-of-state providers of dental-related services qualified in their states to provide these services.

(2) A licensed provider participating in the MAA dental program may be reimbursed only for those services that are within his or her scope of practice.

(3) The provider shall bill the department and its clients according to WAC 388-87-010 and 388-87-015.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1150, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1200 Prior authorization. (1) The following services require prior approval:

(a) Nonemergent surgical procedures as described under WAC 388-86-095;

(b) Nonemergent hospital admissions as described under WAC 388-86-050 and 388-87-070;

(c) Orthodontic treatment as described under WAC 388-535-1000 (3)(f);

(d) Cast base partial dentures;

(e) Coronal polishing and scaling for children seven years of age and under; or

(f) Selected procedures determined by the department.

(2) When requesting prior approval, the department shall require the dental provider to submit, in writing, sufficient objective clinical information to establish medical necessity including, but not limited to:

(a) A physiological description of the disease, injury, impairment, or other ailment;

(b) Pertinent laboratory findings;

(c) X-ray reports; and

(d) Patient profiles.

(3) The department shall approve a request when the requested service meets the criteria in WAC 388-535-1000(2), Scope of coverage.

(4) The department shall deny a request for dental services when the requested service is:

(a) Not medically necessary as defined under WAC 388-500-0005; or

(b) A service, procedure, treatment, device, drug, or application of associated service which MAA or the Health Care Financing Administration (HCFA) consider investigative or experimental on the date the service is provided.

(5) The department may require a second opinion and/or consultation before the approval of any elective oral surgical procedure.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1200, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1250 Orthodontic coverage for DSHS clients. The department shall cover orthodontia care when:

(1) Prior authorized;

(2) A client is eligible for EPSDT/healthy kids services; and

(3) A client meets one of the following categories:

(a) A child with clefts and congenital or acquired craniofacial anomalies:

(i) Cleft lip and palate, cleft palate, and cleft lip with alveolar process involvement;

(ii) Craniofacial anomalies, including but not limited to:

(A) Hemifacial microsomia;

(B) Craniosynostosis syndromes;

(C) Cleidocranial dysplasia;

(D) Arthrogryposis;

(E) Marfans syndrome; or

(F) Other syndromes by review;

(iii) Other diseases/dysplasia with significant facial growth impact, e.g., juvenile rheumatoid arthritis (JRA); or

(iv) Post traumatic, post radiation, or post burn jaw deformity.

(b) A child with severe malocclusions which include one or more of the following:

(i) A severe skeletal disharmony;

(ii) A severe overjet resulting in functional impairment;

(iii) A severe vertical overbite resulting in palatal impingement; and/or damage to the mandibular labial tissues.

(c) A child with other malformations resulting in severe functional impairment shall be reviewed for medical necessity.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1250, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1300 Access to baby and child dentistry (ABCD) program. (1) The access to baby and child dentistry (ABCD) program is a demonstration project in Spokane County, established to increase access to dental services for Medicaid eligible infants, toddlers, and preschoolers.

(2) Children eligible for the ABCD program shall be four years of age and under and residing in Spokane County.

(3) Dental providers certified by the University of Washington continuing education program shall provide ABCD services.

(4) In addition to services provided under the medical assistance administration (MAA) dental care program, the following services are provided:

(a) Family oral health education; and

(b) Case management services.

(5) Clients who do not comply with program requirements may be disqualified from the ABCD program. The client remains eligible for regular MAA dental coverage.

(6) MAA pays enhanced fees to ABCD-certified participating providers for the targeted services.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1300, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1350 Payment methodology—Dental services. (1) For covered services provided to eligible clients, MAA shall reimburse dentists and related providers on a fee-for-service or contract basis, subject to the exceptions and restrictions listed under WAC 388-535-1100, Noncovered dental services and WAC 388-535-1400 Dental payment limits.

(2) In general maximum allowable fees (MAFs) for dental services provided to adult clients are based on the department's historical reimbursement rates, updated for legislatively authorized vendor rate increases.

(3) MAA may pay providers a higher reimbursement rate for selected dental services provided to children eighteen years and younger in order to increase children's access to dental services.

(4) Maximum allowable fees (MAFs) for dental services provided to children are set as follows:

(a) The department's historical reimbursement rates for various procedures are compared to usual and customary charges.

(b) The department consults with and seeks input from representatives of the provider community to identify program areas/concerns that need to be addressed.

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(c) The department consults with dental experts and public health professionals to identify and prioritize dental services/ procedures in terms of their effectiveness in improving and/or promoting children's dental health.

(d) Legislatively authorized vendor rate increases and/or earmarked appropriations for children's dental services are allocated to specific procedures based on this priority list and considerations of access to services.

(e) Larger percentage increases are given to those procedures which have been identified as most effective in improving and/or promoting children's dental health.

(f) Budget-neutral rate adjustments are made as appropriate based on the department's evaluation of utilization trends, effectiveness of interventions, and access issues.

(5) Dental anesthesia services for all eligible clients are reimbursed on the basis of base anesthesia units (BAU) plus time. Payment for dental anesthesia is calculated as follows:

(a) Dental procedures are assigned five base anesthesia units;

(b) Twelve minutes constitute one unit of time. When a dental procedure requiring anesthesia results in multiple time units and a remainder (less than twelve minutes), the remainder or fraction shall be considered as one time unit;

(c) Time units are added to the five base anesthesia units and multiplied by the anesthesia conversion factor;

(d) The formula for determining reimbursement for dental anesthesia is: (5.0 base anesthesia units + time units) x conversion factor r = payment.

(6) Dental hygienists shall be paid at the same rate as dentists for services allowed under The Dental Hygienist Practice Act.

(7) Licensed denturists or dental laboratories billing independently shall be paid at MAA's allowance for prosthodontics.

(8) Fee schedule changes are made whenever vendor rate increases or decreases are authorized by the legislature.

(9) The department uses the American Dental Association's Current Dental Terminology, Second Edition (CDT-2) as the basis for identification of dental services. The department supplements this list with state-assigned procedure codes to identify services which do not fit exactly into the CDT-2 descriptions.

(10) The department may adjust maximum allowable fees to reflect changes in the services or procedure code descriptions.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1350, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1400 Dental payment limits. (1) Provision of covered services to a client eligible for a medical care program constitutes acceptance by the provider of the department's rules and fees.

(2) Participating providers shall bill the department their usual and customary fees.

(3) Payment for dental services is based on the department's schedule of maximum allowances. Fees listed in the MAA fee schedule are the maximum allowable fees.

(4) Payment to the provider will be the lesser of the billed charge (usual and customary fee) or the department's maximum allowable fee.

(5) If a covered service is performed for which no fee is listed, the service shall be paid "By Report."

(6) Clients shall be responsible for payment as described under WAC 388-087-010 for services not covered under the client's medical care program.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1400, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1450 Payment—Denture laboratory services. (1) A dentist using the services of an independent denture laboratory shall request services for an MAA client in the same manner he or she requests services for his or her private patient.

(2) An independently practicing denturist may bill the department directly. No reimbursement shall be made to a dentist for services performed and billed by an independent denturist.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1450, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1500 Payment—Dental-related hospital services. The department shall pay for medically necessary dental-related hospital inpatient and outpatient services according to WAC 388-87-070 and 388-87-072.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1500, filed 12/6/95, effective 1/6/96.]

WAC 388-535-1550 Dental care provided out-of-state. (1) The department shall authorize and provide comparable dental care services to clients who are temporarily outside of the state to the same extent that such dental care services are furnished to clients in the state, subject to the same exceptions and limitations as in-state clients.

(2) The department shall not provide out-of-state dental care to clients receiving medical care services as defined under WAC 388-500-0005. The department shall cover dental services in designated bordering cities for eligible clients.

(3) Out-of-state dental providers shall meet the same criteria for payment as in-state providers.

[Statutory Authority: Initiative 607, 1995 c 18 2nd sp.s. and 74.08.090. 96-01-006 (Order 3931), § 388-535-1550, filed 12/6/95, effective 1/6/96.]

Chapter 388-538 WAC MANAGED CARE

WAC

388-538-001	Purpose.
388-538-050	Definitions.
388-538-060	Healthy options eligibility and choice.
388-538-070	Managed care payment.
388-538-080	Healthy options managed care exemptions.
388-538-090	Client's choice of primary care provider.
388-538-095	Healthy options scope of care.
388-538-100	Managed care emergency services.
388-538-110	Client grievances.
388-538-120	Client request for a second medical opinion.
388-538-130	Removal of client from healthy options.
388-538-140	Quality of care.
388-538-150	Managed care medical audit.

WAC 388-538-001 Purpose. For contracts effective on or after July 1, 1993, the department may contract with health care plans or primary care case managers to provide medical

services directly to a client or arrange for a client to receive medical care according to the contract between the department and a plan or primary care case managers.

[Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-001, filed 8/11/93, effective 9/11/93. Formerly WAC 388-83-010 (part).]

WAC 388-538-050 Definitions. For the purpose of this chapter:

(1) "Emergency services" shall mean medical or other health services which are rendered for a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (a) Placing the patient's health in serious jeopardy;
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

(2) "Enrolled client" means a client eligible for Medicaid and receiving services from a health care plan or primary care case management provider who has a contract with the department.

(3) "Health care plan" or "plan" means an organization contracting with the department to provide managed care to the client by providing and/or paying for medical services covered by the department to an eligible enrolled client in exchange for a contracted rate or management fee.

(4) "Managed care" means a comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- (a) With or assigned to a primary care provider;
- (b) With or assigned to a plan; or
- (c) With an independent provider, who is responsible for arranging or delivering all contracted medical care.

(5) "Persons with special health care needs" means persons having ongoing health conditions that:

- (a) Have a biologic, psychologic, or cognitive basis;
- (b) Have lasted or are virtually certain to last for at least one year; and
- (c) Produce one or more of the following sequelae:

(i) Significant limitation in areas of physical, cognitive, or emotional function;

(ii) Dependency on medical or assistive devices to minimize limitation of function or activities;

(iii) In addition for children:

(A) Significant limitation in social growth or developmental function;

(B) Need for psychologic, educational, medical or related services over and above the usual for the child's age; or

(C) Special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.

(6) "Primary care provider (PCP)" means a provider who has responsibility for supervising, coordinating, and providing initial and primary care to clients, initiating referrals for specialist care, and maintaining the continuity of patient care. A primary care provider shall be either:

- (a) A physician, who meets the criteria under WAC 388-87-007;

(b) An advanced registered nurse practitioner (ARNP), who meets the criteria under WAC 388-87-007; or

(c) A licensed physician assistant.

(7) "Primary care case management (PCCM)" means a model of health care where a physician, ARNP, physician assistant, community/migrant health center, health department, or clinic agrees to provide primary health care services and to arrange and coordinate other preventative, specialty, and ancillary health care in exchange for a contracted payment for each client managed.

(8) "Timely provision of services" means a client has the right to receive medically necessary health care without unreasonable delay.

[Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-050, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-050, filed 8/11/93, effective 9/11/93.]

WAC 388-538-060 Healthy options eligibility and choice. (1) A client is required to enroll in the department's "healthy options" (HO) managed care when that client:

(a) Is eligible for one of the medical programs subject to mandatory enrollment as determined by the department;

(b) Resides in one of the department's contracted managed care service areas;

(c) Is not exempted by the department per WAC 388-538-080; and

(d) Is not removed from HO enrollment by the department per WAC 388-538-130.

(2) American Indians or Alaskan Natives (AI/AN) are those individuals meeting the provisions of 25 U.S.C. 1603 (c)-(d) as of April 30, 1998 (printed format available from the Government Printing Office, Washington, DC). They have the following options:

(a) Enrolling with an HO primary care case manager (PCCM), which include Indian health service direct-care clinics, clinics operated by tribes, and urban Indian health centers; or

(b) Voluntarily selecting an HO contracted managed care plan; or

(c) Requesting an exemption from enrollment in managed care based solely on their status as an AI/AN.

(3) An AI/AN who does not make a choice under subsection (2) of this section will be assigned to an HO PCCM if the client lives in a PCCM area. HO PCCMs are described in subsection (2)(a) of this section. A client who is assigned under this subsection is entitled to request and obtain removal from the PCCM assignment at any time.

(4) A client who is a Medicare beneficiary is not currently eligible to enroll with an HO managed care plan.

(5) Except for clients who are AI/AN, if the client does not choose an HO managed care plan, the department assigns the client to a HO plan in the client's area.

(6) The client will be given an opportunity to select a primary care provider from their HO managed care plan's available providers.

(7) If the client does not choose a primary care provider (PCP), the plan assigns the client a PCP.

(8) A client may change their PCP once a year for any reason. For more frequent PCP changes, the client must

notify the plan of the request and a reason showing good cause. If the plan denies the change, the client may:

(a) Appeal to the plan; or

(b) Ask the department for a fair hearing; or

(c) Appeal to the plan and request a fair hearing from the department.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-060, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-060, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-060, filed 8/11/93, effective 9/11/93.]

WAC 388-538-070 Managed care payment. The department shall pay for managed care as follows:

(1) Under a capitated system:

(a) A set rate to a plan for contracted health care provided to the client; and

(b) The plan has one year from the date services are provided to an SSI client to submit claims:

(i) To the department to be considered towards meeting the stop-loss deductible; and

(ii) For the department to make payments to the plan once the deductible is satisfied.

(2) Under a PCCM model in which the contract is between the department and the health care provider, a monthly management fee in addition to a fee for covered services provided to the client;

(3) Under a PCCM model in which the contract is between the department and a plan, a monthly management fee to the plan to be divided between the plan and the primary care provider, in addition to a fee to the health care provider for covered services provided to the client.

[Statutory Authority: RCW 74.08.090. 96-24-073, § 388-538-070, filed 12/2/96, effective 1/2/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-070, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-070, filed 8/11/93, effective 9/11/93.]

WAC 388-538-080 Healthy options managed care exemptions. (1) Only a client or their representative (RCW 7.70.065) may request an exemption from enrollment to a healthy options (HO) managed care plan. "Exemption" means the client is excused from mandatory enrollment when they have not yet enrolled with or been assigned to an HO plan. If a client asks for an exemption, they are not enrolled until the department approves or denies the request and any related fair hearing is held and decided.

(2) A client is exempted from mandatory enrollment in an HO managed care plan if:

(a) Based on the department's evaluation of objective medical evidence, all of the following are met:

(i) The client has multiple, complex, or severe medical diagnoses; and

(ii) The client's established provider is not with any available managed care plan; and

(iii) There is a written treatment plan; and

(iv) The treatment plan requires frequent change or monitoring; and

(v) Disruption of client's care would be harmful; or

(b) Prior to enrollment, the client scheduled a surgery with a provider not available to the client in an HO managed care plan (or after enrollment it is discovered that the provider is not in the client's current plan) and the surgery is scheduled within the first thirty days of enrollment; or

(c) The client is an AI/AN as specified in WAC 388-538-060(2) and requests exemption; or

(d) On a case-by-case basis, the client presents evidence that the HO program does not provide medically necessary care which is reasonably available and accessible as offered to the client. Medically necessary care is not considered reasonably available and accessible when the client:

(i) Is homeless or is expected to live in temporary housing for less than one hundred twenty days from the date the client requests the exemption; or

(ii) Is limited English speaking or hearing impaired, and the client can communicate with a provider not in an HO managed care plan who speaks in the client's language; or

(iii) Shows that travel to a Medicaid HO provider is unreasonable when compared to travel to a non-HO Medicaid provider. This is shown when the client has:

(A) To travel over twenty-five miles one-way to the nearest managed care PCP who is accepting clients and the current PCP is closer and not in an available HO managed care plan; or

(B) A travel time of over forty-five minutes one-way to the nearest HO managed care PCP who is accepting clients, when the travel time to the current PCP, who is not in an available HO managed care plan, is less; or

(C) Other transportation difficulties making it unreasonable to get primary medical services under managed care; or

(iv) Is pregnant and wishes to continue her established course of prenatal care with an obstetrical provider who is not available to her through an HO plan (or, after enrollment, when the established provider becomes unavailable through HO during the course of treatment); or

(v) Presents other evidence that exemption is appropriate based on their circumstances, as evaluated by the department.

(3) The client's period of exemption is limited by the department to the time period the circumstances or conditions that caused the exemption are expected to exist.

(4) The client remains exempt as provided in subsection (1) of this section and receives timely notice by telephone or in writing when their request is denied. The department's reasons for the denial are given before the client is required to enroll in HO. The notice to the client contains:

(a) The action the department intends to take;

(b) The reasons for the intended action;

(c) The specific rule or regulation supporting the action;

(d) The client's right to request a fair hearing, including the circumstances under which the fee-for-service status is continuing, if a hearing is requested; and

(e) A full translation into the client's primary language when the client has limited English proficiency.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-080, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090. 96-24-074, § 388-538-080, filed 12/2/96, effective 1/1/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-080, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-080, filed 8/11/93, effective 9/11/93.]

WAC 388-538-090 Client's choice of primary care provider. (1) Each client enrolled in managed care shall have a primary care provider (PCP).

(2) A client shall have an opportunity to choose a PCP from available providers.

(3) A plan shall assign a client to a PCP when the client enrolls in a plan and does not choose PCP in the plan.

(4) A client in managed care shall have the right to change a PCP:

(a) One time during a twelve-month period for any reason; and

(b) For subsequent changes during the twelve-month period, only for documented good cause. If the client is enrolled in managed care with a plan, the client shall notify the plan of the desired change including the name of the new PCP, and the reason for the desired change. If the client is enrolled in a PCCM which does not involve a plan, then the client shall notify the department of the desired change, including the name of the new PCP, and the reason for the desired change.

(5) A client whose request to change PCP is denied may submit a grievance with the plan under WAC 388-538-110 or, if the decision was made by the department, may request a fair hearing under WAC 388-526-2610.

[Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-090, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-090, filed 8/11/93, effective 9/11/93.]

WAC 388-538-095 Healthy options scope of care. A client in the healthy options (HO) managed care program is eligible for the categorically needy scope of medical care as described in WAC 388-529-0100. Those covered services not provided by the HO contracted plan are provided through the department's on fee-for-service basis.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-095, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-095, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-095, filed 8/11/93, effective 9/11/93.]

WAC 388-538-100 Managed care emergency services. (1) The department shall exempt emergencies and emergency transportation services from routine medical care authorization procedures of managed care.

(2) A client shall not be responsible for determining if an emergency exists or for the cost of such determination. For nonemergency conditions, hospital reimbursement for PCCM under WAC 388-87-072(4) shall be limited to a medical evaluation fee as established by the department.

(3) In a medical emergency, the client shall not be financially responsible for covered managed care services provided.

(4) When an emergency does not exist, and the client's PCP does not authorize services, the client shall be financially responsible for further services received only when the client is informed and agrees, in writing, to the responsibility before receiving the services as described under WAC 388-87-010.

[Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-100, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 95-04-033 (Order 3826), § 388-538-100, filed 1/24/95, effective 2/1/95; 93-17-039 (Order 3621), § 388-538-100, filed 8/11/93, effective 9/11/93.]

WAC 388-538-110 Client grievances. (1) A client aggrieved by a decision of a managed care contractor or the department shall have the right to a fair hearing as required under WAC 388-81-040.

(2) A client enrolled in a plan:

(a) Shall exhaust a plan's grievance procedure before requesting a fair hearing, except as provided in subsection (3) of this section;

(b) Shall receive a written decision containing the following information:

(i) Action the plan intends to take;

(ii) Reasons for the intended action;

(iii) The specific information supporting the action;

(iv) Client's right to request a fair hearing;

(v) Full translation into the primary language of the limited English proficient recipient.

(c) May request a fair hearing when a:

(i) Grievance decision is adverse;

(ii) Plan does not respond in writing within thirty days from the date the client requests the grievance.

(3) The client may request a fair hearing at the same time a grievance is filed when:

(a) The plan denies medical care that a client indicates is urgently needed and the client requests a grievance in writing; or

(b) The subject matter of the grievance is one for which a client has a fair hearing right under chapters 34.05 RCW, 388-08 WAC, or this chapter.

(4) The managed care contractor shall advise a client of the client's right to request a fair hearing at the time the contractor notifies the client of the grievance decision.

[Statutory Authority: RCW 74.08.090. 97-04-004, § 388-538-110, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-110, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 94-04-038 (Order 3701), § 388-538-110, filed 1/26/94, effective 2/26/94; 93-17-039 (Order 3621), § 388-538-110, filed 8/11/93, effective 9/11/93.]

WAC 388-538-120 Client request for a second medical opinion. (1) The client enrolled in managed care shall have the right to a second opinion by another physician or specialist:

(a) When the client needs more information as to the medical necessity of medical treatment recommended by the PCP; or

(b) If the client believes the PCP is not authorizing medically necessary care.

(2) If the client is enrolled in a plan, the second opinion physician or specialist shall be a participating provider in the plan. If the client is enrolled with a PCCM, which does not involve a plan, the client shall have the right to a second opinion by another provider or specialist, who is a medical assistance provider.

(3) When medically necessary, the client shall be promptly referred to:

(a) Another participating physician or specialist of a plan, when enrolled in a plan; or

(b) Another provider or specialist when enrolled under PCCM, which does not involve a plan.

[Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-120, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-120, filed 8/11/93, effective 9/11/93.]

WAC 388-538-130 Removal of client from healthy options. (1) Only the department has authority to remove a client from the healthy options (HO) program, but requests for removal can be made by the client, their representative as defined in RCW 7.70.065, or by the client's HO plan. Pending the department's final decision, the client remains enrolled unless staying in HO managed care would adversely affect the client's health status.

(2) The department may remove a client from enrollment in HO when the client:

(a) Is no longer eligible for a medical program subject to enrollment; or

(b) Requests to be removed from HO, and the department approves according to the same criteria given in WAC 388-538-080 (Exemption); or

(c) Is a Medicare beneficiary.

(3) The department may remove a client from HO plan enrollment when the client's HO plan substantiates in writing, to the department's satisfaction that:

(a) The client's behavior is inconsistent with the HO plan's rules and regulations, such as intentional misconduct; and

(b) After medical review and treatment interventions, the client's behavior continues to prevent the provider from safely or prudently providing medical care to the client; and

(c) The client received written notice from their HO plan of the plan's intent to request the client's removal. The plan's notice to the client must include the client's right to use the plan's appeal process to review the plan's request and the client's right to use the department fair hearing process.

The requirement that the plan notify the client is waived if the client's conduct presents the threat of imminent harm to others.

(4) Within thirty days of receiving the plan request to remove a client from HO enrollment, a decision is made by the department. Before a decision is made an attempt is made by the department to contact the client and learn the client's perspective. If the plan's request to remove the client from HO enrollment is approved, the client will be given advance and adequate notice including hearing rights information (ten days in advance of the effective date of the removal).

(5) An HO plan's request to remove a client from HO enrollment will not be approved when it is solely due to an adverse change in the client's health or the cost of meeting the client's needs.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-130, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-130, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-130, filed 8/11/93, effective 9/11/93.]

WAC 388-538-140 Quality of care. The department shall require:

- (1) A plan to appoint a medical director or designee who:
 - (a) Shall be responsible for the plan's quality assurance program and shall review all plan grievances; and
 - (b) Furnishes MAA with a copy of all grievances and a plan's response to such grievances.
- (2) A PCCM not involving a plan to provide adequate documentation for quality assurance review.
- (3) A plan or PCCM to have in place a method to assure consideration of the unique needs of persons with special health care needs as defined in WAC 388-538-050 and to assist with:
 - (a) Early identification of persons with special health care needs;
 - (b) Timely access to health care; and
 - (c) Coordination of health service delivery and community linkages.
- (4) The department shall conduct outreach of various types to accommodate the unique communication needs of some members of the populations served.
- (5) The department shall ensure that clients are given the most important relevant information and a variety of ways to enroll or request exemptions and disenrollments.
- (6) The plan or PCCM shall make reasonable and appropriate accommodations as required under the Americans with Disabilities Act (ADA) for clients who have a mental, physical, or sensory impairment or another limitation which affects the clients' abilities to understand written notices and/or other types of communications.

[Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-140, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-140, filed 8/11/93, effective 9/11/93.]

WAC 388-538-150 Managed care medical audit. (1) At least once a year, the department shall conduct a medical audit of managed care contractors to ensure the quality and accessibility of health care services provided or arranged by the contractors for enrolled clients.

(2) Managed care contractors shall permit such medical audit.

(3) The department may conduct or contract independently for such medical audit.

[Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-150, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-150, filed 8/11/93, effective 9/11/93.]

Chapter 388-539 WAC

ACQUIRED HUMAN IMMUNODEFICIENCY SYNDROME INSURANCE PROGRAM

WAC

388-539-001	Purpose.
388-539-050	Definitions.
388-539-100	Eligibility.
388-539-150	Premium payment.

WAC 388-539-001 Purpose. The department shall administer state funds appropriated to ensure health insurance coverage for a person:

[Title 388 WAC—p. 674]

(1) Incapacitated by acquired human immunodeficiency syndrome (AIDS), as defined under WAC 388-539-050; and

(2) Who meets the department's eligibility requirements described under WAC 388-539-100.

[Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-001, filed 8/11/93, effective 9/11/93.]

WAC 388-539-050 Definitions. For the purpose of this chapter, "acquired human immunodeficiency syndrome" means the illness characterized by the diseases and conditions defined and described by the state board of health under WAC 246-100-011(1).

[Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-050, filed 8/11/93, effective 9/11/93.]

WAC 388-539-100 Eligibility. (1) The department shall pay health insurance premiums for a client with AIDS and who is liable for the health insurance premium, when the client meets the following conditions:

(a) Is ineligible for Medicaid or state-funded medical programs operated by the department;

(b) Is eligible for continuation coverage insurance benefits as provided for by the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, group health insurance, or individual health insurance coverage if cost effective; and

(c) Has personal assets equal to or less than fifteen thousand dollars, excluding a home used as a primary residence, and a car.

(2) A client's eligibility under the program shall cease when the person:

(a) Dies;

(b) Is no longer eligible for insurance under subsection (1) of this section; or

(c) Moves out of state.

[Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-100, filed 8/11/93, effective 9/11/93.]

WAC 388-539-150 Premium payment. The department shall pay a maximum premium payment not to exceed fifty percent of the estimated average monthly expenditure for covered services for a comparable Medicaid client during the same fiscal year.

[Statutory Authority: RCW 74.08.090. 93-17-037 (Order 3619), § 388-539-150, filed 8/11/93, effective 9/11/93.]

Chapter 388-540 WAC

KIDNEY CENTERS

WAC

388-540-001	Purpose.
388-540-005	Definitions.
388-540-010	Services.
388-540-020	Reimbursement.
388-540-030	KDP eligibility.
388-540-040	Transfer of resources without adequate consideration.
388-540-050	Fiscal information.
388-540-060	KDP eligibility determination.

WAC 388-540-001 Purpose. The department shall administer state funds appropriated to assist people with end stage renal disease to meet the costs of their medical care.

(1999 Ed.)

[Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-001, filed 7/28/93, effective 8/28/93.]

WAC 388-540-005 Definitions. For the purpose of administering the state kidney disease program (KDP), the following shall apply:

"Adequate consideration" means that the reasonable value of goods or services received in exchange for transferred property approximates the reasonable value of the property transferred;

"Affiliate" means a facility, hospital, unit, business, or person having an agreement with a kidney center to provide specified services to ESRD patients;

"Application for KDP eligibility" means the form provided by the department which the client completes and submits to determine KDP eligibility;

"Assets" means income or resources or any real or personal property that a person or the person's spouse owns and could convert to cash to be used for support or maintenance;

"Break in service" means a previously certified client does not have medical coverage for a period of time when a new application for eligibility is submitted more than thirty days after the end of a previous certification period;

"Certification" or **"certified"** means the kidney center has determined a client eligible for the KDP for a period of time under this chapter;

"Department" means the department of social and health services;

"End stage renal disease (ESRD)" means that stage of renal impairment which is irreversible and permanent, and requires dialysis or kidney transplantation to ameliorate uremic symptoms and maintain life;

"KDP application period" means the time between the date of application and certification;

"KDP client" means resident of the state with a diagnosis of ESRD;

"Kidney center" means those facilities as defined and certified by the federal government to provide ESRD services and which provide the services specified in this chapter and which promote and encourage home dialysis for a client when medically indicated;

"Recertifying client" means a KDP client who was determined eligible the previous year for the KDP and will continue to qualify under this chapter;

"Resident." Refer to WAC 388-505-0510;

"State kidney disease program (KDP)" means state general funds appropriated to the department to assist clients with ESRD in meeting the cost of medical care;

"Substantial financial change" means:

(1) The elimination of a client's required annual deductible amount; or

(2) The increase or decrease of income or assets by fifteen hundred dollars.

"Transfer" - Refer to WAC 388-500-0005;

"Value-fair market" - Refer to WAC 388-500-0005.

[Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025, 98-06-025, § 388-540-005, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-005, filed 7/28/93, effective 8/28/93.]

(1999 Ed.)

WAC 388-540-010 Services. Generally, the kidney center shall provide, directly or through an affiliate, all physical facilities, professional consultation, personal instructions, medical treatment and care, drugs, dialysis equipment, and supplies necessary for carrying out a medically-sound ESRD treatment program. The kidney center shall provide:

(1) Dialysis for clients with ESRD when medically indicated;

(2) Kidney transplantation treatment for clients with ESRD either directly or by referral, when medically indicated;

(3) Treatment for conditions directly related to ESRD;

(4) Training and supervision of medical, supporting personnel and of clients who are eligible for home dialysis; and

(5) Supplies and equipment for home dialysis.

[Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-010, filed 7/28/93, effective 8/28/93.]

WAC 388-540-020 Reimbursement. The department shall reimburse kidney centers for services described in this chapter to the extent the legislature has appropriated funds and when the center submits documented evidence, satisfactory to the department, showing:

(1) Services for which reimbursement is requested;

(2) Client's financial eligibility for the state kidney disease program under this chapter except reimbursement for services:

(a) Provided to a client location outside the state shall be limited to a period of two weeks per calendar year per client; and

(b) Described under this chapter shall be determined on a case-by-case basis by the department.

[Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-020, filed 7/28/93, effective 8/28/93.]

WAC 388-540-030 KDP eligibility. (1) A client is KDP eligible who meets the following requirements:

(a) Is a Washington state resident;

(b) Has countable resources, not exempted under subsection (2) of this section, equal to or lower than fifteen thousand dollars;

(c) Has countable income as defined under WAC 388-500-0005 equal to or lower than three hundred percent of the federal poverty level (FPL); and

(d) Exhausts or is ineligible for all other resources providing similar benefits to meet the cost of ESRD-related medical care, such as:

(i) Government or private disability programs; or

(ii) Local funds raised for the purpose of providing financial support for a specified ESRD client.

(2) The following resources are exempt:

(a) A home, defined as real property owned by a client as a principal place of residence, together with the property surrounding and contiguous thereto, not to exceed five acres;

(b) Household furnishings; and

(c) An automobile.

[Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025, 98-06-025, § 388-540-030, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090. 93-16-039 (Order 3600), § 388-540-030, filed 7/28/93, effective 8/28/93.]

[Title 388 WAC—p. 675]

WAC 388-540-040 Transfer of resources without adequate consideration. A person may be ineligible for the program if the person knowingly and willfully assigns or transfers nonexempt resources at less than fair market value for the purpose of qualifying or continuing to qualify for the program within two years preceding the date of application.

[Statutory Authority: RCW 74.08.090, 93-16-039 (Order 3600), § 388-540-040, filed 7/28/93, effective 8/28/93.]

WAC 388-540-050 Fiscal information. The kidney center shall provide fiscal information on the department's request. The information shall include:

(1) Accounting information and documentation sufficient to establish the basis for fees for services and/or charges;

(2) Sources and amounts of resources allowing an individual client to verify financial eligibility;

(3) Evidence that all other available resources have been depleted before requests for reimbursement from the state kidney disease program are submitted to the department; and

(4) Other information as the department may require.

[Statutory Authority: RCW 74.08.090, 93-16-039 (Order 3600), § 388-540-050, filed 7/28/93, effective 8/28/93.]

WAC 388-540-060 KDP eligibility determination. The department, kidney center and client shall comply with the following rules to determine KDP eligibility:

(1) The kidney center shall:

(a) Inform the client of the requirements for KDP eligibility as defined in this chapter;

(b) Provide the client with necessary department forms and instructions in a timely manner;

(c) Review the KDP application and documentation;

(d) Determine client eligibility using department policies, rules, and instructions; and

(e) Forward the KDP application and documentation to the medical assistance administration (MAA). If necessary, the department may amend or terminate a client's certification period within thirty days of receipt

(2) A new client shall:

(a) Complete the KDP application and submit any necessary documentation for eligibility determination to the kidney center; and

(b) Apply for Medicaid, obtain a written Medicaid eligibility determination and submit a copy to the kidney center.

(3) A recertifying client shall:

(a) Apply for Medicaid forty-five days before the end of the KDP certification period; and

(i) Obtain a written Medicaid eligibility determination; and

(ii) Submit a copy to the kidney center; or

(b) Be exempt from the requirement in (3)(a) of this subsection when the client has applied for Medicaid in the prior five years and will continue to:

(i) Be denied Medicaid due to:

(A) Failure to meet Medicaid categorical requirements;

(B) Assets exceeding Medicaid resource standards; or

(C) Income exceeding the categorically needy income standards.

(ii) Not meet medically needy spenddown amount because the cost of medical care is:

(A) Less than the spenddown amount; or

(B) Covered by third-party insurance.

(4) The KDP application period is:

(a) One hundred and twenty days for a new client; and

(b) Forty-five days prior to the end of a certification period for a client requesting recertification.

(5) The kidney center may request an extension of application time limits from the department when extenuating circumstances prevent the client from completing the application or recertification process within the specified time limits.

(6) The KDP client shall be certified as KDP eligible for a period of one year from the first day of the month of application unless the client's:

(a) Need for medical coverage is less than one year; or

(b) Assets change substantially, in which case the client must complete a new application for KDP eligibility;

(7) KDP eligibility effective date is the first day of the month of KDP application if the person was eligible at any time during that month. The effective date of KDP eligibility shall be no earlier than four months before the month of KDP application provided the:

(a) Medical services received were covered; and

(b) Person would have been eligible had the person applied.

[Statutory Authority: RCW 74.08.090, 74.04.005 and 74.08.025, 98-06-025, § 388-540-060, filed 2/24/98, effective 3/27/98. Statutory Authority: RCW 74.08.090, 93-16-039 (Order 3600), § 388-540-060, filed 7/28/93, effective 8/28/93.]

Chapter 388-550 WAC HOSPITAL SERVICES

WAC

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WAC 388-550-1000 Applicability. The department shall pay for hospital services provided to eligible clients when:

(1) The eligible client is a patient in a general hospital and the hospital meets the definition in RCW 70.41.020;

(2) The services are medically necessary as defined under WAC 388-500-0005; and

(3) The conditions, exceptions and limitations in this chapter are met.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1050 Definitions. Unless otherwise specified, the terms used in this chapter have the following meaning:

"Accommodation costs" mean the expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made, such as, but not limited to, a regular hospital room, special care hospital room, dietary and nursing services, medical and surgical supplies, medical social services, psychiatric social services, and the use of certain hospital equipment and facilities.

"Acute" means a term describing medical condition of severe intensity with sudden onset.

"Acute care" means care provided by an agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent monitoring by a health care professional in order to maintain their health status (WAC 248-27-015).

"ADATSA/DASA assessment center" means an agency contracted by the division of alcohol and substance

abuse (DASA) to provide chemical dependency assessment for clients and pregnant women in accordance with the alcohol and drug addiction treatment and support act (ADATSA). Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

"Add-on procedure" means a secondary procedure that is performed in addition to another procedure.

"Administrative day" means a day of a hospital stay in which an acute inpatient level of care is no longer necessary, and an appropriate noninpatient hospital placement is not available.

"Admitting diagnosis" means the diagnosis, coded according to the International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM), indicating the medical condition which precipitated the client's admission to an inpatient hospital facility.

"Advance directive" means a document, such as a living will, executed by a client, that tells the client's health care providers and others the client's decisions regarding his or her medical care, particularly whether the client wishes to accept or refuse extraordinary measures to prolong his or her life.

"Aggregate capital cost" means the total cost or the sum of all capital costs.

"Aggregate cost" means the total cost or the sum of all constituent costs.

"Aggregate operating cost" means the total cost or the sum of all operating costs.

"Alcohol and drug addiction treatment and support act (ADATSA)" means the law and the state-funded program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

"Alcoholism and/or alcohol abuse treatment" means the provision of medical social services to an eligible client designed to mitigate or reverse the effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by the provision of a combination of alcohol education sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and their families.

"All-patient grouper (AP-DRG)" means a computer program that determines the diagnosis-related group (DRG) assignments.

"Allowed charges" mean the maximum amount for any procedure that the department will recognize.

"Ancillary hospital costs" mean the expenses incurred by a hospital to provide additional or supporting services to its patients during their hospital stay. Such services include, but are not limited to, laboratory, radiology, drugs, delivery room (including maternity labor room), and operating room (including anesthesia and postoperative recovery rooms).

"Ancillary services" mean additional or supporting services, such as, but not limited to, laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services, provided by a hospital to a patient during his or her hospital stay.

"Approved treatment facility" means a treatment facility, either public or private, profit or nonprofit, approved by DSHS.

"Audit" means an assessment, evaluation, examination, or investigation of a health care provider's accounts, books and records, including:

(1) Medical, financial and billing records pertaining to billed services paid by the department through Medicaid or other state programs, by a person not employed or affiliated with the provider, for the purpose of verifying the service was provided as billed and was allowable under program regulations; and

(2) Financial, statistical and medical records, including mathematical computations and special studies conducted supporting Medicare cost reports HCFA Form 2552, submitted to the department for the purpose of establishing program rates of reimbursement to hospital providers.

"Audit claims sample" means a subset of the universe of paid claims from which the sample is drawn, whether based upon judgmental factors or random selection. The sample may consist of any number of claims in the population up to one hundred percent. See also **"random claims sample"** and **"stratified random sample."**

"Authorization number" means a nine-digit number assigned by MAA that identifies individual requests for approval of services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

"Authorization requirement" means MAA's requirement that a provider present proof of medical necessity to MAA, usually before providing certain medical services or equipment to a client. This takes the form of a request for authorization of the service(s) and/or equipment, including a complete, detailed description of the client's diagnosis and/or any disabling conditions, justifying the need for the equipment or the level of service being requested.

"Average hospital rate" means the weighted average of hospital rates in the state of Washington.

"Bad debt" means an operating expense or loss incurred by a hospital because of uncollectible accounts receivables.

"Base period" means, for purposes of establishing a provider rate, a specific period or timespan used as a reference point or basis for comparison.

"Base period costs" mean costs incurred in or associated with a specified base period.

"Beneficiary" means a recipient of Social Security benefits, or a person designated by an insuring organization as eligible to receive benefits.

"Benefit period" means a "spell of illness" for Medicare payments. For part A coverage, the benefit period begins on the first day a Medicare beneficiary is furnished inpatient hospital or extended care services by a qualified provider, and ends when the beneficiary has been out of the hospital or other covered facility for sixty-consecutive days.

"Billed charge" - See **"usual and customary charge."**

"Blended rate" means a mathematically weighted average rate.

"Border area hospital" means a hospital located in an area defined by state law as: Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, or The

Dalles; Idaho - Coeur d'Alene, Lewiston, Moscow, Priest River or Sandpoint.

"Bundled services" mean interventions which are incidental to the major procedure and are not separately reimbursable.

"Buy-in premium" means a monthly premium the state pays so a client is enrolled in part A and/or part B Medicare.

"By report" means a method of reimbursement in which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules by requiring the provider to submit a "report" describing the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Callback" means keeping physician staff on duty beyond their regularly scheduled hours, or having them return to the facility after hours to provide unscheduled services; usually associated with hospital emergency room, surgery, laboratory and radiology services.

"Capital-related costs" mean the component of operating costs related to capital assets, including, but not limited to:

- (1) Net adjusted depreciation expenses;
- (2) Lease and rentals for the use of depreciable assets;
- (3) The costs for betterment and improvements;
- (4) The cost of minor equipment;
- (5) Insurance expenses on depreciable assets;
- (6) Interest expense; and
- (7) Capital-related costs of related organizations that provide services to the hospital.

It excludes capital costs due solely to changes in ownership of the provider's capital assets.

"Case mix complexity" means, from the clinical perspective, the condition of the patients treated and the treatment difficulty associated with providing care. Administratively, it means the resource intensity demands that patients place on an institution.

"Case mix index" means a measure of the costliness of cases treated by a hospital relative to the cost of the average of all Medicaid hospital cases, using diagnosis-related group weights as a measure of relative cost.

"Charity care" means necessary hospital health care rendered to indigent persons, as defined in this section, to the extent that these persons are unable to pay for the care or to pay the deductibles or coinsurance amounts required by a third-party payer, as determined by the department.

"Chemical dependency" means an alcohol or drug addiction; or dependence on alcohol and one or more other psychoactive chemicals.

"Children's hospital" means a hospital primarily serving children.

"Coinsurance" - See WAC 388-500-005.

"Comorbidity" means of, relating to, or caused by a disease other than the principal disease.

"Complication" means a disease or condition occurring subsequent to or concurrent with another condition and aggravating it.

"Comprehensive hospital abstract reporting system (CHARS)" means the department of health's hospital data collection, tracking and reporting system.

"Contract hospital" means a licensed hospital located in a selective contracting area, which is awarded a contract to participate in the department's selective contracting hospital program.

"Contractual adjustment" means the difference between the amount billed at established charges for the services provided and the amount received or due from a third-party payer under a contract agreement. A contractual adjustment is similar to a trade discount.

"Conversion factor" means a hospital-specific dollar amount that reflects the average cost of treating Medicaid clients in a given hospital. See "**cost-based conversion factor (CBCF)**" and "**negotiated conversion factor (NCF)**."

"Cost proxy" means an average ratio of costs to charges for ancillary charges or per diem for accommodation cost centers used to determine a hospital's cost for the services where the hospital has charges for the services has does not report costs in corresponding centers in its Medicare cost report.

"Cost report" means the HCFA Form 2552, Hospital and Hospital Health Care Complex Cost Report, completed and submitted annually by a provider:

- (1) To Medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and
- (2) To Medicaid to establish appropriate DRG and RCC reimbursement.

"Costs" mean MAA-approved operating, medical education, and capital-related costs as reported and identified on the HCFA 2552 form.

"Cost-based conversion factor (CBCF)" means a hospital-specific dollar amount that reflects the average cost of treating Medicaid clients in a given hospital. It is calculated from the hospital's cost report by dividing the hospital's costs for treating Medicaid clients during a base period by the number of Medicaid discharges during that same period and adjusting for the hospital's case mix. See also "**conversion factor**" and "**negotiated conversion factor**."

"County hospital" means a hospital established under the provisions of chapter 36.62 RCW.

"Covered service" means a service that is included in the Medicaid program and is within the scope of the eligible client's medical care program.

"Critical care services" mean services for critically ill or injured patients in a variety of medical emergencies that require the constant attendance of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications). For Medicaid reimbursement purposes, critical care services must be provided in a Medicare qualified critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility, to qualify for reimbursement as a special care level of service.

"Current procedural terminology (CPT)" means a systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians; it is published annually by the American Medical Association (AMA).

"Customary charge or fee" - See "**Allowed charges**" and "**usual and customary charge**."

"Customary charge payment limit" means the limit placed on aggregate diagnosis-related group (DRG) payments to a hospital during a given year to assure that DRG payments do not exceed the hospital's charges to the general public for the same services.

"Day outlier" means a case that requires MAA to make additional payment to the hospital provider but which does not qualify as a high-cost outlier. See "**day outlier payment**" and "**day outlier threshold**."

"Day outlier payment" means the additional amount paid to a disproportionate share hospital for a client five years old or younger who has a prolonged inpatient stay which exceeds the day outlier threshold but whose charges for care fall short of the high cost outlier threshold. The amount is determined by multiplying the number of days in excess of the day outlier threshold and the administrative day rate.

"Day outlier threshold" means the average number of days a client stays in the hospital for an applicable DRG before being discharged, plus twenty days.

"Deductible" means the amount a beneficiary is responsible for, before Medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible.

"Detoxification" means treatment provided to persons who are recovering from the effects of acute or chronic intoxication or withdrawal from alcohol or other drugs.

"Diabetic education program" means a comprehensive, multidisciplinary program of instruction offered by an MAA-approved facility to diabetic clients on dealing with diabetes, including instruction on nutrition, foot care, medication and insulin administration, skin care, glucose monitoring, and recognition of signs/symptoms of diabetes with appropriate treatment of problems or complications.

"Diagnosis code" means a set of alphabetic, numeric, or alpha-numeric characters assigned by the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as a shorthand symbol to represent the nature of a disease.

"Diagnosis-related group (DRG)" means a classification system which categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases, the presence of a surgical procedure, patient age, presence or absence of significant co-morbidities or complications, and other relevant criteria.

"Direct medical education costs" means the direct costs of providing an approved medical residency program as recognized by Medicare.

"Discharging hospital" means the institution releasing a client from the acute care hospital setting.

"Disproportionate share payment" means additional payment(s) made by the department to a hospital which serves a disproportionate number of Medicaid and other low-income clients and which qualifies for one or more of the disproportionate share hospital programs identified in the state plan.

"Disproportionate share program" means a program that provides additional payments to hospitals which serve a

disproportionate number of Medicaid and other low-income clients.

"Dispute conference" means a meeting for deliberation during a provider administrative appeal.

(1) At the first level of appeal it is usually a meeting between auditors and the audited provider and/or staff to resolve disputed audit findings, clarify interpretation of regulations and policies, provide additional supporting information and/or documentation.

(2) At the second level of appeal the dispute conference is a more formal hearing, held by the office of contracts and asset management which issues a decision articulating the department's final position on the contested issue(s).

(3) See WAC 388-81-042.

"Distinct unit" means a Medicare-certified distinct area for rehabilitation services within a general acute care hospital or a department-designated unit in a children's hospital.

"DRG" - See **"diagnosis-related group."**

"DRG-exempt services" mean services which are paid for through other methodologies than those using cost-based or negotiated conversion factors.

"DRG payment" means the payment made by MAA for a client's inpatient hospital stay; it is calculated by multiplying the hospital-specific conversion factor by the DRG relative weight for the client's medical diagnosis.

"DRG relative weight" means the average cost of a certain DRG divided by the average cost for all cases in the entire data base for all DRGs, expressed in comparison to a designated standard cost.

"Drug addiction and/or drug abuse treatment" means the provision of medical and rehabilitative social services to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by the provision of a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities to detoxified addicts and their families.

"Elective procedure or surgery" means a nonemergent procedure or surgery that can be scheduled at convenience.

"Emergency medical condition" - See WAC 388-500-0005, Medical definitions.

"Emergency medical expense requirement (EMER)" - See WAC 388-500-0005, Medical definitions.

"Emergency room" or **"emergency facility"** means an organized, distinct hospital-based facility available twenty-four hours a day for the provision of unscheduled episodic services to patients who present for immediate medical attention, and capable of providing emergency services including trauma.

"Emergency services" mean medical services, including maternity services, required by and provided to a patient after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ

or part. Inpatient maternity services are treated as emergency services.

"Equivalency factor" means a conversion factor used, in conjunction with two other factors (cost-based conversion factor and the ratable factor), to determine the level of state-only program payment.

"Exempt hospital" means a hospital that is either not located in a selective contracting area or is exempted by the department and is reimbursed for services to MAA clients through methodologies other than those using cost-based or negotiated conversion factors.

"Experimental treatment" means a course of treatment or procedure that:

(1) Is not generally accepted by the medical profession as effective and proven;

(2) Is not recognized by professional medical organizations as conforming to accepted medical practice;

(3) Has not been approved by the federal Food and Drug Administration (FDA) or other requisite government body;

(4) Is still in clinical trials, or has been judged to need further study;

(5) Is covered by the federal law requiring provider institutional review of patient consent forms, and such review did not occur; or

(6) Is rarely used, novel, or relatively unknown, and lacks authoritative evidence of safety and effectiveness.

"Facility triage fee" means the amount the medical assistance administration will pay a hospital for a medical evaluation or medical screening examination, performed in the hospital's emergency department, of a nonemergent condition of a *healthy options* client covered under the primary care case management (PCCM) program. This amount corresponds to the professional care level 1 or level 2 service.

"Fiscal intermediary" means Medicare's designated fiscal intermediary for a region and/or category of service.

"Formula price" means the hospital's payment rate, which is the product of the hospital-specific conversion factor multiplied by the DRG weight for the given hospitalization.

"Global surgery days" mean the number of preoperative and follow-up days that are included in the reimbursement to the physician for the major surgical procedure.

"Graduate medical education costs" mean the direct and indirect costs of providing medical education in teaching hospitals.

"Grouper" - See **"all-patient grouper (AP-DRG)"**.

"HCFA 2552" - See **"cost report."**

"Health care team" means a team of professionals and/or paraprofessionals involved in the care of a client.

"High-cost outlier" means a case with extraordinarily high costs when compared to other cases in the same DRG, in which the allowed charges exceed three times the applicable DRG payment or twenty-eight thousand dollars, whichever is greater.

"Hospice" means a medically-directed, interdisciplinary program of palliative services which is provided under arrangement with a Title XVIII Washington state-licensed and Title XVIII-certified Washington state hospice for terminally ill clients and the clients' families.

"Hospital" means an entity which is licensed as an acute care hospital in accordance with applicable state laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

"Hospital admission" means admission as an inpatient to a hospital, for a stay of twenty-four hours or longer.

"Hospital cost report" - See "cost report."

"Hospital facility fee" - See "facility triage fee."

"Hospital market basket index" means a measure, expressed as a percentage, of the annual inflationary costs for hospital services, as measured by Data Resources, Inc., (DRI).

"Hospital peer group" means the peer group categories adopted by the former Washington state hospital commission for rate-setting purposes:

(1) Group A - rural hospitals paid under a ratio-of-costs-to-charges (RCC) methodology;

(2) Group B - urban hospitals without medical education programs;

(3) Group C - urban hospitals with medical education programs; and

(4) Group D - specialty hospitals and/or hospitals not easily assignable to the other three peer groups.

"Indigent patient" means a patient who has exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below two hundred percent of the federal poverty standards (adjusted for family size), or is otherwise not sufficient to enable the individual to pay for his or her care, or to pay deductibles or coinsurance amounts required by a third-party payor.

"Indirect medical education costs" means the indirect costs of providing an approved medical residency program as recognized by Medicare.

"Inflation adjustment" means, for cost inflation, the hospital inflation factor determined by Data Resources, Inc., (DRI) and published in the DRI/McGraw-Hill Report. See also **"hospital market basket index."** For charge inflation, it means the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the comprehensive hospital abstract reporting system (CHARS) standard reports three and four.

"Inpatient hospital" means a hospital authorized by the department of health to provide inpatient services.

"Inpatient services" mean all services provided directly or indirectly by the hospital to a patient subsequent to admission and prior to discharge, and includes, but is not limited to, the following services: Bed and board; medical, nursing, surgical, pharmacy and dietary services; maternity services; psychiatric services; all diagnostic and therapeutic services required by the patient; the technical and/or professional components of certain services; use of hospital facilities, medical social services furnished by the hospital, and such drugs, supplies, appliances and equipment as required by the patient; transportation services subsequent to admission and prior to discharge; and services provided by the hospital within twenty-four hours of the patient's admission as an inpatient.

"Institution" - See WAC 388-500-0005, Medical definitions.

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"Interdisciplinary group (IDG)" means the team, including a physician, a registered nurse, a social worker, and a pastoral or other counselor, which is primarily responsible for the provision or supervision of care and services for a Medicaid client.

"Intermediary" - See "fiscal intermediary."

"International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Edition" means the systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical designations (coding).

"Intervention" means any medical or dental service provided to a client that modifies the medical or dental outcome for that client.

"Length of stay (LOS)" means the number of days of inpatient hospitalization. The phrase more commonly means the average length of hospital stay for patients based on diagnosis and age, as determined by the Commission of Professional and Hospital Activities and published in a book entitled *Length of Stay by Diagnosis, Western Region*. See also **"professional activity study (PAS)"**.

"Length of stay extension request" means a request from a hospital provider for MAA to approve a client's hospital stay exceeding the average length of stay for the client's diagnosis and age.

"Lifetime hospitalization reserve" means, under the Medicare Part A benefit, the nonrenewable sixty hospital days that a beneficiary is entitled to use during his or her lifetime for hospital stays extending beyond ninety days per benefit period. See also **"reserve days."**

"Low-cost outlier" means a case with extraordinarily low costs when compared to other cases in the same DRG, in which the allowed charges for the case is less than or equal to ten percent of the applicable DRG payment or four hundred dollars, whichever is greater. Reimbursement in such cases is determined by multiplying the case's allowed charges by the hospital's RCC ratio.

"Low income utilization rate" means a formula represented as $(A/B)+(C/D)$ in which:

(1) The numerator A is the hospital's total patient services revenue under the state plan, plus the amount of cash subsidies for patient services received directly from state and local governments in a period;

(2) The denominator B is the hospital's total patient services revenue (including the amount of such cash subsidies) in the same period as the numerator;

(3) The numerator C is the hospital's total inpatient service charge attributable to charity care in a period, less the portion of cash subsidies described in (1) of this definition in the period reasonably attributable to inpatient hospital services. The amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the state plan); and

(4) The denominator D is the hospital's total charge for inpatient hospital services in the same period as the numerator.

"Major diagnostic category (MDC)" means one of the twenty five mutually exclusive groupings of principal diagnosis areas in the DRG system. The diagnoses in each MDC

correspond to a single major organ system or etiology and, in general, are associated with a particular medical specialty.

"Market basket index" - See "hospital market basket index."

"Medicaid cost proxy" means a figure developed to approximate or represent a missing cost figure.

"Medicaid inpatient utilization rate" means a formula represented as X/Y in which:

(1) The numerator X is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the state plan in a period.

(2) The denominator Y is the hospital's total number of inpatient days in the same period as the numerator's. Inpatient day includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

"Medical care services" - See WAC 388-500-0005, Medical definitions.

"Medical education costs" mean the expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program.

"Medical screening evaluation" means the service(s) provided by a physician or other practitioner to determine whether an emergent medical condition exists. See also "facility triage fee."

"Medical stabilization" means a return to a state of constant and steady function. It is commonly used to mean the client is adequately supported to prevent further deterioration.

"Medically indigent (MI)" - See WAC 388-500-0005, Medical definitions.

"Medically indigent person" means a person certified by the department of social and health services as eligible for the limited casualty program-medically indigent (LCP-MI) program. See also "indigent patient."

"Medicare cost report" means the annual cost data reported by a hospital to Medicare on the HCFA form 2552.

"Medicare crossover" means a claim involving a client who is eligible for both Medicare benefits and Medical Assistance.

"Medicare fee schedule (MFS)" means the official HCFA publication of Medicare policies and relative value units for the resource based relative value scale (RBRVS) reimbursement program.

"Medicare Part A" means that part of the Medicare program that helps pay for inpatient hospital services, which may include, but are not limited to:

- (1) A semi-private room;
- (2) Meals;
- (3) Regular nursing services;
- (4) Operating room;
- (5) Special care units;
- (6) Drugs and medical supplies;
- (7) Laboratory services;
- (8) X-ray and other imaging services; and
- (9) Rehabilitation services.

Medicare hospital insurance also helps pay for post-hospital skilled nursing facility care, some specified home

health care, and hospice care for certain terminally ill beneficiaries.

"Medicare part B" means that part of the Medicare program that helps pay for, but is not limited to:

- (1) Physician services;
- (2) Outpatient hospital services;
- (3) Diagnostic tests and imaging services;
- (4) Outpatient physical therapy;
- (5) Speech pathology services;
- (6) Medical equipment and supplies;
- (7) Ambulance;
- (8) Mental health services; and
- (9) Home health services.

"Medicare buy-in premium" - See "buy-in premium."

"Medicare payment principles" mean the rules published in the federal register regarding reimbursement for services provided to Medicare clients.

"Mentally incompetent" means a client who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the client has been declared competent for purposes which include the ability to consent to sterilization.

"Multiple occupancy rate" means the rate customarily charged for a hospital room with two or more patient beds.

"Negotiated conversion factor (NCF)" means a negotiated hospital-specific dollar amount which is used in lieu of the cost-based conversion factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital. See also "conversion factor" and "cost-based conversion factor."

"Nonallowed service or charge" means a service or charge that cannot be billed to the department or client.

"Noncontract hospital" means a licensed hospital located in a selective contracting area (SCA) but which does not have a contract to participate in the selective contracting hospital program.

"Noncovered service or charge" means a service or charge that is not covered by medical assistance, including, but not limited to, such services or charges as a private room, circumcision, and video recording of the procedure.

"Nonemergent hospital admission" means any inpatient hospitalization of a client who does not have an emergent condition, as defined in WAC 388-500-0005, Emergency services.

"Nonparticipating hospital" means a noncontract hospital, as defined in this section.

"Operating costs" mean all expenses incurred in providing accommodation and ancillary services, excluding capital and medical education costs.

"Orthotic device" means a fitted surgical apparatus designed to activate or supplement a weakened or atrophied limb or bodily function.

"Out-of-state hospital" means any hospital located outside the state of Washington or outside the designated border areas in Oregon and Idaho.

"Outlier set-aside factor" means the amount by which a hospital's cost-based conversion factor is reduced for payments of high cost outlier cases.

"Outlier set-aside pool" means the total amount of payments for high cost outliers which are funded annually based on payments for high cost outliers during the year.

"Outliers" mean cases with extraordinarily high or low costs when compared to other cases in the same DRG.

"Outpatient" means a client who is receiving medical services in other than an inpatient hospital setting.

"Outpatient care" means medical care provided in other than an inpatient hospital setting, such as in a hospital outpatient or emergency department, a physician's office, the patient's own home, or a nursing facility.

"Outpatient hospital" means a hospital authorized by the department of health to provide outpatient services.

"Outpatient stay" means a hospital stay of less than or approximating twenty-four hours, except that cases involving the death of a client, delivery or initial care of a newborn, or transfer to another acute care facility are not deemed outpatient stays.

"Pain treatment facility" means an MAA-approved inpatient facility for pain management, in which a multidisciplinary approach is used to teach clients various techniques to live with chronic pain.

"Participating hospital" means a licensed hospital that accepts MAA clients.

"PAS length of stay (LOS)" means the average length of hospital stay for patients based on diagnosis and age, as determined by the Commission of Professional and Hospital Activities and published in a book entitled *Length of Stay by Diagnosis, Western Region*. See also "**professional activity study (PAS)**" and "**length of stay**."

"Patient consent" means the informed consent of the client and/or the client's guardian to the procedure(s) to be performed upon or the treatment provided to the client, evidenced by the client's or guardian's signature on a consent form.

"Peer group" - See "**hospital peer group**."

"Peer group cap" means the reimbursement limit set for hospital peer groups B and C, established at the seventieth percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs.

"Per diem charge" means the daily charge per client that a facility may bill or is allowed to receive as payment for its services.

"Personal comfort items" mean items and services which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member.

"Physical medicine and rehabilitation (PM&R)" means a comprehensive inpatient rehabilitative program coordinated by a multidisciplinary team at an MAA-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for a diagnostic category for which the client shows significant potential functional improvement.

"Physician standby" means physician attendance without direct face-to-face patient contact and does not involve provision of care or services.

"Physician's current procedural terminology (CPT)" - See "**CPT**."

"Plan of treatment" or "plan of care" means the written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.

"Pregnant and postpartum women (PPW)" mean eligible female clients who are pregnant or within the first one hundred sixty days following delivery.

"Principal diagnosis" means the medical condition determined after study of the patient's medical records to be the principal cause of the patient's hospital stay.

"Principal procedure" means a procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.

"Private room rate" means the rate customarily charged by a hospital for a one-bed room.

"Professional activity study (PAS)" means the compilation of inpatient hospital data by diagnosis and age, conducted by the Commission of Professional and Hospital Activities, which resulted in the determination of an average length of stay for patients. The data are published in a book entitled *Length of Stay by Diagnosis, Western Region*.

"Professional component" means the part of a procedure or service that relies on the physician's professional skill or training, or the part of a reimbursement that recognizes the physician's cognitive skill.

"Prognosis" means the probable outcome of a patient's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the patient's probable life span as a result of the illness.

"Prolonged service" means direct face-to-face patient services provided by a physician, either in the inpatient or outpatient setting, which involve time beyond what is usual for such services.

"Prospective payment system (PPS)" means a system that sets payment rates for a pre-determined period for defined services, before the services are provided. The payment rates are based on economic forecasts and the projected cost of services for the pre-determined period.

"Prosthetic device" - See WAC 388-500-0005, Medical definitions.

"Psychiatric hospitals" mean designated psychiatric facilities, state psychiatric hospitals, designated distinct part pediatric psychiatric units, and Medicare-certified distinct part psychiatric units in acute care hospitals.

"Public hospital district" means a hospital district established under chapter 70.44 RCW.

"Random claims sample" means a sample in which all of the items are selected randomly, using a random number table or computer program, based on a scientific method of assuring that each item has an equal chance of being included in the sample. See also "**audit claims sample**" and "**stratified random sample**."

"Ratable" means a hospital-specific adjustment factor applied to the cost-based conversion factor (CBCF) to determine state-only program payment rates to hospitals.

"Ratio of costs to charges (RCC)" means the methodology used to pay hospitals for services exempt from the DRG payment method. It also refers to the factor applied to

a hospital's allowed charges for medically necessary services to determine payment to the hospital for these DRG-exempt services.

"Readmission" means the situation in which a client who was admitted as an inpatient and discharged from the hospital is back as an inpatient within seven days as a result of one or more of the following: A new flair of illness, complication(s) from the first admission, a therapeutic admission following a diagnostic admission, a planned readmission following discharge, or a premature hospital discharge.

"Rebasing" means the process of recalculating the hospital cost-based conversion factors using more current data.

"Recalibration" means the process of recalculating DRG relative weights using more current data.

"Rehabilitation units" mean specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals that meet Medicare criteria for distinct part rehabilitation units.

"Relative weights" - See **"DRG relative weights."**

"Remote hospitals" mean hospitals located outside selective contracting areas (SCAs), or which:

- (1) Are more than ten miles from the nearest contract hospital in the SCA; and
- (2) Have fewer than seventy five beds; and
- (3) Have fewer than five hundred Medicaid admissions in a two-year period.

"Reserve days" mean the days beyond the ninetieth day of hospitalization of a Medicare patient for a benefit period or spell of illness. See also **"lifetime hospitalization reserve."**

"Retrospective payment system" means a system that sets payment rates for defined services according to historic costs. The payment rates reflect economic conditions experienced in the past.

"Revenue code" means a nationally-used three-digit coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

"Room and board" means services provided in a nursing facility, including:

- (1) Assistance in the activities of daily living.
- (2) Socialization activities.
- (3) Administration of medication.
- (4) Maintenance of the resident's room.
- (5) Supervision and assistance in the use of durable medical equipment and prescribed therapies.

See **"accommodation costs"** for services included in the hospital room and board category.

"Rural health clinic" means a clinic that is located in a rural area designated as a shortage area, and is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

"Rural hospital" means a rural health care facility capable of providing or assuring availability of health services in a rural area.

"Secondary diagnosis" means a diagnosis other than the principal diagnosis for which an inpatient is admitted to a hospital.

"Selective contracting area (SCA)" means an area in which hospitals participate in competitive bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by Medicaid patients.

"Selective hospital contracting program" or "selective contracting" means a competitive bidding program for hospitals within a specified geographic area to provide inpatient hospital services to medical assistance clients.

"Semi-private room rate" means a rate customarily charged for a hospital room with two to four beds; this charge is generally lower than a private room rate and higher than a ward room. See also **"multiple occupancy rate."**

"Short stay" means a hospital stay of less than or approximating twenty-four hours where an inpatient admission was not appropriate.

"Special care unit" means a Medicare-certified hospital unit where intensive care, coronary care, psychiatric intensive care, burn treatment or other specialized care is provided.

"Specialty hospitals" mean children's hospitals, psychiatric hospitals, cancer research centers or other hospitals which specialize in treating a particular group of clients or diseases.

"Spenddown" means the amount of excess income MAA has determined that a client has available to meet his or her medical expenses. The client becomes eligible for Medicaid coverage only after he or she meets the spenddown requirement.

"Stat laboratory charges" mean the charges by a laboratory for performing a test or tests immediately. "Stat." is the abbreviation for the Latin word "statim" meaning immediately.

"State plan" means the plan filed by the department with the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS), outlining how the state will administer the hospital program.

"Stratified random sample" means a sample consisting of claims drawn randomly, using statistical formulas, from each stratum of a universe of paid claims stratified according to the dollar value of the claims. See also **"audit claims sample"** and **"random claims sample."**

"Subacute care" means care to a patient which is less intrusive than that given at an acute care hospital. Skilled nursing, nursing care facilities and other facilities provide subacute care services.

"Surgery" - The medical diagnosis and treatment of injury, deformity or disease by manual and instrumental operations. For reimbursement purposes, surgical procedures are those designated in CPT as procedure codes 10000 to 69999.

"Swing-bed days" means a bed day on which an inpatient is receiving skilled nursing services in a swing bed at the hospital's census hour. The hospital bed must be certified by the health care financing administration for both acute care and skilled nursing services.

"Teaching hospital" means, for purposes of the teaching hospital assistance program disproportionate share hospital (THAPDSH), the University of Washington medical center and Harborview hospital.

"Technical component" means the part of a procedure or service that relates to the equipment set-up and techni-

cian's time, or the part of a reimbursement that recognizes the equipment cost and technician time.

"Tertiary care hospital" means a specialty care hospital providing highly specialized services to clients with more complex medical needs than acute care services.

"Total patient days" means all patient days in a hospital for a given reporting period, excluding days for skilled nursing, nursing care, and observation days.

"Transfer" means to move a client from one acute care facility to another.

"Transferring hospital" means the hospital transferring a client to another acute care facility.

"Trauma care facility" means a facility certified by the department of health as a level I, II or III facility.

"UB-92" means the uniform billing document intended for use nationally by hospitals, hospital-based skilled nursing facilities, home health, and hospice agencies in billing third party payers for services provided to clients.

"Unbundled services" mean services which are excluded from the DRG payment to a hospital, including but not limited to, physician professional services and certain nursing services.

"Uncompensated care" - See **"charity care."**

"Uniform cost reporting requirements" means a standard accounting and reporting format as defined by Medicare.

"Uninsured indigent patient" means an individual who receives hospital inpatient and/or outpatient services and who cannot meet the cost of services provided because the individual has no or insufficient health insurance or other resources to cover the cost.

"Usual and customary charge (UCC)" means the charge customarily made to the general public for a procedure or service, or the rate charged other contractors for the service if the general public is not served.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1050, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1100 Hospital coverage. (1) Admission of a medical care client to a hospital shall be covered only when the admission is requested by the client's attending physician. For nonemergent hospital admissions, "attending physician" shall mean the client's primary care provider, or the primary provider of care to the patient at the time of hospitalization. For emergent admissions, "attending physician" shall mean the staff member who has hospital privileges who evaluates the client's medical condition upon the client's arrival at the hospital.

(2) In areas where the choice of hospitals is limited by managed care or selective contracting, the department shall not be responsible for payment under fee-for-service for hospital care and/or services:

(a) Provided to managed care clients enrolled in the department's managed care plan, unless the services are excluded from the health carrier's capitation contract with the department and are covered under the medical assistance program; or

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(b) Received by a medical care client from a nonparticipating hospital in a selective contracting area (SCA) unless exclusions in WACs 388-550-4600 and 388-550-4700 apply.

(3) The department shall provide chemical-dependent pregnant Medicaid clients up to twenty-six days of inpatient hospital care for hospital-based detoxification, medical stabilization, and drug treatment when:

(a) An alcohol, drug addiction and treatment support act assessment center verifies the need for the inpatient care; and

(b) The hospital chemical dependency treatment unit is certified by the division of alcohol and substance abuse.

See WAC 388-550-6250 for outpatient hospital services for chemical-dependent pregnant Medicaid clients.

(4) The department shall cover medically necessary services provided to eligible clients in a hospital setting for the care or treatment of teeth, jaws, or structures directly supporting the teeth:

(a) If the procedure requires hospitalization; and

(b) A physician or dentist gives or directly supervises such services.

(5) The department shall pay hospitals for services provided in special care units when the provisions of WAC 388-550-2900 (9)(c) are met.

(6) All services shall be subject to review and approval as stated in WAC 388-87-025.

(7) For inpatient psychiatric admissions, whether voluntary or involuntary, see chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1200 Limitations on hospital coverage. Hospital coverage under the medical assistance program is limited for certain eligible clients, including, but not limited to, the following:

(1) Medical care clients enrolled with the department's managed care carriers as follows:

(a) Comprehensive risk contracts are subject to their respective carriers' policies and procedures regarding hospital services;

(b) Primary care case management contracts are subject to the clients' primary care physicians' approval;

(c) For emergency care exemptions, see WAC 388-538-100.

(2) The department shall limit coverage for clients eligible for the medically indigent (MI) program to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, WAC 388-529-2950, and this chapter. The department shall not cover out-of-state hospital or other medical care for clients under the MI program.

(3) The department shall not cover out-of-state medical care for clients under the medical care services program.

(4) See WAC 388-550-1100(3) for chemical-dependent pregnant clients.

(5) The department shall limit care in a state mental institution or an approved psychiatric facility to categorically needy and medically needy clients under twenty-one years of age, or sixty-five years of age or older.

(6)(a) The department shall pay clients eligible for both Medicare and Medicaid only for their deductibles and coin-

surance for hospitalization, unless the client has exhausted his or her Medicare part A benefits.

(b) If such benefits are exhausted, the department shall pay for hospitalization for such client subject to MAA rules.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1300 Revenue code categories and subcategories. (1) For reimbursement and audit purposes, hospitals shall report and bill all services provided to a medical care client under the appropriate cost centers or revenue codes, except the following services which are subject to current procedural terminology codes and rates when provided in an outpatient setting:

- (a) Laboratory/pathology;
- (b) Radiology, diagnostic and therapeutic;
- (c) Nuclear medicine;
- (d) Computerized tomography scans, magnetic resonance imaging, and other imaging services;
- (e) Physical therapy;
- (f) Occupational therapy;
- (g) Speech/language therapy; and
- (h) Other hospital services as identified and published by the department.

(2) Revenue code categories in this chapter shall be as listed in the state of Washington's UB-92 procedure manual, implemented October 1, 1993, which was patterned after the national uniform billing data element specifications adopted by the national uniform billing committee.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1400 Covered revenue codes for hospital services. (1) The department shall cover the following revenue code categories for both inpatient and outpatient hospitalizations:

- (a) "Pharmacy," except that:
 - (i) Subcategories "take-home drugs," "experimental drugs," and "other pharmacy" are not covered; and
 - (ii) Subcategory "nonprescription" is covered for inpatients only;
 - (b) "Intravenous (IV) therapy," except subcategory "other IV therapy";
 - (c) "Medical/surgical supplies and devices," except for the following subcategories:
 - (i) "Take home supplies";
 - (ii) "Prosthetic devices";
 - (iii) "Oxygen - take home"; and
 - (iv) "Other supplies/devices."
 - (d) "Oncology," except subcategory "other oncology";
 - (e) "Respiratory services," except subcategory "other respiratory services";
 - (f) Subcategories "general classification" and "minor surgery" under the "operating room services" category;
 - (g) "Anesthesia," except subcategories "acupuncture" and "other anesthesia";
 - (h) "Blood storage and processing," except subcategory "other blood storage and processing";

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(i) "Other imaging services," except subcategory "other image services";

(j) "Emergency room," except subcategory "other emergency room";

(k) "Pulmonary function," except subcategory "other pulmonary function";

(l) "Cardiology," except subcategory "other cardiology";

(m) "Magnetic resonance imaging (MRI)," except subcategory "other MRI";

(n) "Cast room," except subcategory "other cast room";

(o) "Recovery room," except subcategory "other recovery room";

(p) "Labor room/delivery," except for subcategories "circumcision" and "other labor room/delivery";

(q) "EKG/ECG (electrocardiogram)," except subcategory "other EKG/ECG";

(r) "EEG (electroencephalogram)," except subcategory "other EEG";

(s) "Gastrointestinal services," except subcategory "other gastroenteritis";

(t) "Treatment or observation room," except subcategory "other treatment room";

(u) "Lithotripsy," except subcategory "other lithotripsy"; and

(v) "Organ acquisition," except for subcategories "unknown donor" and "other organ."

(2) Except for certain services, such as inpatient hospice services covered by MAA pursuant to other rules, the department shall cover the following revenue code categories and/or subcategories for inpatient hospitalizations only:

(a) "Room and board - private, medical, or general," except subcategory "hospice";

(b) "Semi-private room and board" (two to four beds), except subcategory "hospice";

(c) "Nursery for newborns and premature babies";

(d) "Intensive care," except subcategory "post-ICU";

(e) "Coronary care," except subcategory "post-CCU";

(f) "Laboratory," except subcategory "renal patient (home)";

(g) "Laboratory pathological";

(h) "Radiology," both "diagnostic" and "therapeutic";

(i) "Nuclear medicine";

(j) "Physical therapy," "occupational therapy," and "speech-language therapy";

(k) "CT (computed tomographic) scans";

(l) "Operating room services," subcategories "organ transplant other than kidney" and "kidney transplant only";

(m) "Clinic," subcategory "chronic pain center" only;

(n) "Ambulance," subcategory "neonatal ambulance services (support crews)" only;

(o) "Other donor bank" category, except that subcategories "peripheral blood stem cell harvesting" and "reinfusion" are limited only to facilities approved by the medical assistance administration (MAA).

In addition to specifically excluded subcategories, the subcategory "other" in each category shall not be covered.

(3) Except for certain services, such as inpatient hospice services covered by MAA pursuant to other rules, the department shall cover the following revenue code categories for outpatient hospital services only:

- (a) "Ambulatory surgical care";
- (b) "Outpatient services";
- (c) Subcategories "general classification" and "dental clinic," under "clinic";
- (d) Subcategory "rural health clinic," under "free-standing clinic";
- (e) "Drugs requiring specific identification," except covered only for certified kidney centers;
- (f) "Hospice services";
- (g) "Respite care";
- (h) "Inpatient renal dialysis";
- (i) "Hemodialysis - outpatient or home";
- (j) "Peritoneal dialysis - outpatient or home";
- (k) "Continuous ambulatory peritoneal dialysis - outpatient or home";
- (l) "Continuous cycling peritoneal dialysis - outpatient or home";
- (m) "Miscellaneous dialysis";
- (n) Subcategories "education/training" and "weight loss," under the "other therapeutic services" category, except limited to facilities approved by MAA.

In addition to specifically excluded subcategories, the subcategory "other" in each category shall not be covered.

(4) The department shall cover the following revenue code categories and/or subcategories subject to the following specific limitations:

(a) The "private (deluxe)" and "room and board - ward" categories shall be reimbursed at the semi-private hospital room rates.

(b) All inpatient psychiatric services shall be subject to the policies and procedures of the mental health division, and reimbursed only to department-approved psychiatric facilities. See chapter 246-318 WAC. Inpatient psychiatric revenue codes include, but are not limited to:

(i) The subcategory "psychiatric" under all "room and board" categories;

(ii) The subcategory "psychiatric" under the "intensive care" category;

(iii) The "psychiatric/psychological treatments" category; and

(iv) The "psychiatric/psychological services" category.

(c) The department shall reimburse the subcategory "detoxification" under all room and board categories only to detoxification facilities approved by the division of alcohol and substance abuse.

(d) The subcategory "rehabilitation" under all "room and board" categories shall be reimbursed only to MAA-approved rehabilitation facilities.

(e) Only the subcategories "chemical-using pregnant women" and "administrative days" shall be covered in the "other room and board" category.

(f) Subcategory "nonprescription drugs" under the category "pharmacy" shall be covered for inpatient hospitalizations only. See WAC 388-550-1400 (1)(a)(ii). Certain exemptions apply for pregnant women as described in WAC 388-86-024 (2)(c). For coverage of nonprescription drugs, see WAC 388-530-110 and 388-530-1150.

(g) The subcategories "renal patient (home)" and "non-routine dialysis" under category "laboratory" shall be reim-

bursed in the outpatient setting only to Medicare-certified kidney centers.

(h) Subcategory "chronic pain center" under the "clinic" category shall be reimbursed only to MAA-approved chronic pain treatment facilities.

(i) Only the subcategory "neonatal ambulance services (support crews)" under the "ambulance" category shall be covered, and only for inpatient hospitalizations.

(j) The category "drugs requiring specific identification" shall be reimbursed only for outpatients and only to Medicare-approved kidney centers.

(k) Subcategories "education/training" and "weight loss," under the "other therapeutic service" category, shall be reimbursed only to MAA-approved facilities.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.1500, [74.09.]530 and 43.20.B.020. 98-01-124, § 388-550-1400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1500 Noncovered revenue codes.

(1) Revenue code subcategories titled "other" shall not be covered by the medical assistance administration (MAA), unless otherwise specified.

(2) The department shall not cover the following revenue code categories in either an inpatient or outpatient setting:

- (a) "All-inclusive rate";
- (b) "Other room and board," except as indicated in WAC 388-550-1400 (4)(e);
- (c) "Leave of absence";
- (d) "Not assigned" (all such categories);
- (e) "Special charges";
- (f) "Incremental nursing charge rate";
- (g) "All-inclusive ancillary";
- (h) "Pharmacy" subcategories for "take home" and "experimental drugs";
- (i) "Durable medical equipment (other than renal)";
- (j) "Blood" (and blood products);
- (k) "Audiology";
- (l) "Clinic," except as specified in WAC 388-550-1400 (3)(c);
- (m) "Free-standing clinic," except as specified in WAC 388-550-1400 (3)(d);
- (n) "Osteopathic services";
- (o) "Ambulance," except as specified in WAC 388-550-1400 (4)(i);
- (p) "Skilled nursing";
- (q) "Medical social services";
- (r) "Home health aide (home health)" and "other visits (home health)";
- (s) "Units of service (home health)";
- (t) "Oxygen (home health)";
- (u) "Medicare/surgical supplies";
- (v) "Home IV therapy services";
- (w) "Preventive care services";
- (x) "Other diagnostic services";
- (y) "Professional fees" (all such categories); and
- (z) "Patient convenience items."

(3) The department shall not cover the following subcategories in the "other therapeutic service" category:

- (a) "General classification";
- (b) "Recreational therapy";

- (c) "Cardiac rehabilitation";
- (d) "Drug rehabilitation," except under the chemically-using pregnant (CUP) women program;
- (e) "Alcohol rehabilitation," except under the CUP program; and
- (f) "Air fluidized support beds."

(4) The department shall not cover the following subcategories under the "free-standing clinic" category:

- (a) "General classification";
- (b) "Rural health - home";
- (c) "Family practice"; and
- (d) "Other clinic."

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1600 Specific items/services not covered. The department shall not cover certain hospital items/services for any hospital stay including, but not limited to, the following:

- (1) Personal care items such as, but not limited to, slippers, toothbrush, comb, hair dryer, and make-up;
- (2) Telephone/telegraph services or television/radio rentals;
- (3) Medical photographic or audio/videotape records;
- (4) Crisis counseling;
- (5) Psychiatric day care;
- (6) Ancillary services, such as respiratory and physical therapy, performed by regular nursing staff assigned to the floor or unit;
- (7) Standby personnel and travel time;
- (8) Routine hospital medical supplies and equipment such as bed scales;
- (9) Handling fees and portable X-ray charges;
- (10) Room and equipment charges ("rental charges") for use periods concurrent with another room or similar equipment for the same client;
- (11) Cafeteria charges;
- (12) Services and supplies provided to nonpatients, such as meals and "father packs"; and
- (13) Standing orders. The department shall cover routine tests and procedures only if the department determines such services are medically necessary, according to the following criteria. The procedure or test:
 - (a) Is specifically ordered by the admitting physician or, in the absence of the admitting physician, the hospital staff having responsibility for the client (e.g., physician, advanced registered nurse practitioner, or physician assistant);
 - (b) Is for the diagnosis or treatment of the individual's condition; and
 - (c) Does not unnecessarily duplicate a test available or made known to the hospital which is performed on an outpatient basis prior to admission; or
 - (d) Is performed in connection with a recent admission.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1700 Hospital services—Prior approval. (1) Providers of hospital-related services to clients

not enrolled with the department's managed care carriers shall obtain prior approval from the medical assistance administration (MAA) for hospital services requiring prior approval. For inpatient psychiatric admissions and inpatient treatment for alcohol and other substance abuse, see chapter 246-318 and 246-326 WAC respectively.

(2) The department shall require that for medical care clients not enrolled with the department's managed care carriers, providers receive prior approval from the department for the following hospital-related services:

(a) All nonemergent admissions to or planned inpatient hospital surgeries in nonparticipating hospitals in selective contracting areas;

(b) Inpatient detoxification, medical stabilization, and drug treatment for a pregnant Medicaid client as described under WAC 388-550-1100(3);

(c) Cataract surgery that does not meet requirements in WAC 388-86-030;

(d) The following surgical procedures, regardless of the diagnosis or place of service:

(i) Hysterectomies for clients forty-four years and younger;

(ii) Reduction mammoplasty; and

(iii) Surgical bladder repair.

(e) All physical medicine and rehabilitation (PM&R) inpatient hospital stays, even when provided by MAA-approved PM&R contract facilities (see WAC 388-550-2300);

(f) All outpatient magnetic resonance imaging and magnetic resonance angiography procedures;

(g) All nonemergent inpatient hospital transfers (see WAC 388-550-3600);

(h) All out-of-state non-emergent hospital stays;

(i) Hospital-related services as described in WAC 388-550-1800 when not provided in an MAA-approved facility; and

(j) Services in excess of the department's established limits.

(3) The department shall inform providers which diagnosis codes from the International Classification of Diseases, 9th Revision, Clinical Modification and procedure codes from physicians' current procedural terminology require prior authorization for nonemergent hospital admissions.

(4) When a client's hospitalization exceeds the number of days allowed by WAC 388-550-4300(2):

(a) The hospital shall, within sixty days after discharge, submit to MAA a request for authorization of the extra days with adequate medical justification, to include at a minimum the following:

(i) History and physical examination;

(ii) Social history;

(iii) Progress notes and doctor's orders for the entire length of stay;

(iv) Treatment plan/critical pathway; and

(v) Discharge summary.

(b) The department shall approve or deny a length of stay extension request within fifteen working days of receiving the request.

(5) The department shall require prior approval for out-of-state hospital admissions of clients not enrolled with

department's managed care carriers, except for emergent hospitalizations. The department shall inform providers which codes from the current revision of ICD-9CM are designated as emergent diagnosis codes. The nature of the client's emergent medical condition must be fully documented in the client's hospital's records.

(6) The department shall not reimburse ambulance providers for ambulance transports in cases involving hospital transfers without prior authorization by the department.

(7) The department shall require that providers receive prior approval from the department for medical transportation to out-of-state treatment programs or services authorized by the department for clients not enrolled with the department's managed care carriers.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1750 Services requiring approval. (1) The department shall require that for medical services clients not enrolled with the department's managed care carriers, providers receive approval from the department for the following:

(a) Hospital length-of-stay extensions, in order for the provider to receive payment for the additional hospital days;

(b) All hospital readmissions within seven days of discharge; and

(c) All hospitalizations billed under "miscellaneous diagnosis-related group (DRG)," four hundred sixty-eight.

(2) Providers shall obtain approval for:

(a) Length-of-stay extensions, during or immediately after the extension;

(b) Readmissions, immediately after the readmission; and

(c) Hospitalizations under "miscellaneous DRG," four hundred sixty-eight, immediately after the hospitalization.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1750, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1800 Services—Contract facilities. The department shall reimburse certain services without requiring prior authorization when such services are provided in medical assistance administration (MAA)-approved contract facilities. These services include, but are not limited to, the following:

(1) All transplant procedures specified in WAC 388-550-1900(2);

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC 388-550-2400;

(3) Polysomnograms and multiple sleep latency tests for clients one year of age and older (allowed only in outpatient hospital settings), as described under WAC 388-550-6350;

(4) Diabetes education (allowed only in outpatient hospital setting), as described under WAC 388-550-6400; and

(5) Weight loss program (allowed only in outpatient hospital setting), as described under WAC 388-550-6450.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-1900 Transplant coverage. (1) The department shall pay for transplant procedures only for eligible clients who:

(a) Meet the criteria in WAC 388-550-2000; and

(b) Are not otherwise subject to a managed care plan.

(2) The department shall cover the following transplant procedures:

(a) Solid organs involving the heart, kidney, liver, lung, heart-lung, pancreas, kidney-pancreas;

(b) Bone marrow and peripheral stem cell (PSC);

(c) Skin grafts; and

(d) Corneal transplants.

(3) For procedures covered under subsections (2)(a) and (b) of this section, the department shall pay facility charges only to those medical centers that meet the standards and conditions:

(a) Established by the department; and

(b) Specified in WAC 388-550-2100 and 388-550-2200.

(4) The department shall pay facility charges for skin grafts and corneal transplants to any qualified medical facility, subject to the limitations in this chapter.

(5) The department shall deem organ procurement fees included in the reimbursement to the transplant facility. The department may make an exception to this policy and reimburse these fees separately to a transplant facility when an eligible medical care client is covered by a third-party payer which will pay for the organ transplant procedure itself but not for the organ procurement.

(6) The department shall, without requiring prior authorization, pay for up to fifteen matched donor searches per client approved for a bone marrow transplant. The department shall require prior authorization for matched donor searches in excess of fifteen per bone marrow transplant client.

(7) The department shall not pay for experimental transplant procedures. In addition, the department shall consider experimental those services including, but not limited to, the following:

(a) Transplants of three or more different organs during the same hospital stay;

(b) Solid organ and bone marrow transplants from animals to humans; and

(c) Transplant procedures used in treating certain medical conditions for which use of the procedure has not been generally accepted by the medical community or for which its efficacy has not been documented in peer-reviewed medical publications.

(8) The department shall pay for a solid organ transplant procedure only once per client's lifetime, except in cases of organ rejection by the client's immune system during the original hospital stay. The department shall cover bone marrow, PSC, skin grafts and corneal transplants whenever medically necessary.

(9) In reviewing coverage for transplant services, the department shall consider cost benefit analyses on a case-by-case basis.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-1900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2000 Medical criteria—Transplant services. (1) The department shall pay for transplant surgery in accordance with the provisions of this chapter for an eligible client who has:

(a) End-stage organ disease, except end-stage renal disease and diseases treatable with bone marrow or peripheral stem cell (PSC) transplants;

(b) A critical medical need for a transplant and a poor prognosis for survival without one, except for kidney, skin graft, or corneal transplants;

(c) Tried all other appropriate medical and surgical therapies that customarily yield both short and long term survival comparable to that of a transplant;

(d) Been identified by the transplant facility as a candidate for whom the transplant, as a therapy, has a high probability of a successful clinical outcome, defined as a better than sixty percent survival rate after one year; and

(e) Agreed to long-term adherence to a disciplined medical regimen.

(2) Medical care clients enrolled with the department's managed care carriers shall be subject to their respective carriers' criteria and policies.

(3) The department shall not cover transplant procedures for clients with the following medical conditions:

(a) An irreversible terminal state in which the client has had multi-organ system failure, is moribund, or on life support, defined as mechanical systems such as ventilators or heart-lung respirators which are used to supplement or supplement the normal autonomic functions of a person;

(b) Current active and incurable or metastatic malignancy within other organ systems;

(c) An active infection that will interfere with the client's recovery;

(d) Irreversible renal or hepatic disease that substantially affects longevity. MAA shall exempt from this criterion clients requesting a kidney, liver, bone marrow, PSC, skin graft or corneal transplant;

(e) Significant atherosclerotic vascular disease or atherosclerotic coronary disease that substantially affects longevity. MAA shall not apply this criterion to clients requesting a heart, bone marrow, PSC, skin graft or corneal transplant;

(f) Any other major irreversible disease likely to substantially limit life expectancy to three years or less;

(g) Inability to follow a drug regimen or maintain necessary therapies and/or other prescribed health care regimens;

(h) Ventilator dependence, except when used in short-term, acute situations. The department shall not consider ventilator dependence for transplants involving bone marrow, PSC, skin or cornea;

(i) Current use or history within the past year of alcohol or substance abuse and/or smoking, or failure to have abstained for long enough to indicate low likelihood of recidivism; and

(j) A history of behavior pattern or psychiatric illness that has not been assessed, treated or considered stable, that would likely lead to nonconformance or interference with a disciplined medical regimen.

(4) The department may deny coverage for corneal transplants for clients with an associated disease severe enough to

prevent visual improvement, such as macular degeneration or diabetic retinopathy.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2100 Requirements—Transplant facilities.

(1) The department shall require a transplant facility to meet the following requirements in order to be reimbursed for transplant services provided to medical care clients. The facility shall have:

(a) An approved certificate of need (CON) from the state department of health (DOH) for the type(s) of transplant procedure(s) to be performed, except that MAA shall not require CON approval for peripheral stem cell (PSC), skin graft and corneal transplant facilities;

(b) Approval from the United Network of Organ Sharing (UNOS) to perform transplants, except that MAA shall not require UNOS approval for PSC, skin graft and corneal transplant facilities; and

(c) Been approved by the department as a center of excellence transplant center for the specific organ(s) or procedure(s) the facility proposes to perform. An out-of-state transplant center shall be a Medicare-certified facility participating in that state's Medicaid program.

(2) The department shall consider a facility for approval as a transplant center of excellence when the facility submits to the department a copy of its DOH-approved CON for transplant services, or documentation that it has, at a minimum:

(a) Organ-specific transplant physicians for each organ or transplant team. The transplant surgeon and other responsible team members shall be experienced and board-certified or board-eligible practitioners in their respective disciplines, including, but not limited to, the fields of cardiology, cardiovascular surgery, anesthesiology, hemodynamics and pulmonary function, hepatology, hematology, immunology, oncology, and infectious diseases. The department shall consider this requirement met when the facility submits to the department a copy of its DOH-approved CON for transplant services;

(b) Component teams which are integrated into a comprehensive transplant team with clearly defined leadership and responsibility. Transplant teams shall include, but not be limited to:

(i) A team-specific transplant coordinator for each type of organ;

(ii) An anesthesia team available at all times;

(iii) A nursing service team trained in the hemodynamic support of the patient and in managing immunosuppressed patients;

(iv) Pathology resources for studying and reporting the pathological responses of transplantation;

(v) Infectious disease services with both the professional skills and the laboratory resources needed to discover, identify, and manage a whole range of organisms; and

(vi) Social services resources.

(c) An organ procurement coordinator;

(d) A method ensuring that transplant team members are familiar with transplantation laws and regulations;

(e) An interdisciplinary body and procedures in place to evaluate and select candidates for transplantation;

(f) An interdisciplinary body and procedures in place to ensure distribution of donated organs in a fair and equitable manner conducive to an optimal or successful patient outcome;

(g) Extensive blood bank support;

(h) Patient management plans and protocols;

(i) Written policies safeguarding the rights and privacy of patients; and

(j) Satisfied the annual volume and survival rates criteria for the particular transplant procedures performed at the facility, as specified in WAC 388-550-2200(2).

(3) In addition to the requirements of subsection (2) of this section, a facility being considered for approval as a transplant center of excellence shall submit a copy of its approval from the United Network for Organ Sharing (UNOS), or documentation showing that the facility:

(a) Participates in the national donor procurement program and network; and

(b) Systematically collects and shares data on its transplant program(s) with the network.

(4) The department shall apply the following specific requirements to PSC transplant facilities:

(a) A PSC transplant facility may receive approval from the department to do PSC:

(i) Harvesting, if it has its own apheresis equipment which meets federal or American Association of Blood Banks (AABB) requirements;

(ii) Processing, if it meets AABB quality of care requirements for human tissue/tissue banking; and/or

(iii) Reinfusion, if it meets the criteria established by the Foundation for the Accreditation of Hematopoietic Cell Therapy.

(b) A hospital may purchase PSC processing and harvesting services from other department-approved processing providers.

(c) The department shall not reimburse a PSC transplant facility for AABB inspection and certification fees related to PSC transplant services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2200 Transplant requirements—COE. (1) The department shall measure the effectiveness of transplant centers of excellence (COE) using the performance criteria in this section. Unless otherwise waived by the department, the department shall apply these criteria to a facility during both initial and periodic evaluations for designation as a transplant COE. The COE performance criteria shall include, but not be limited to:

(a) Meeting annual volume requirements for the specific transplant procedures for which approved;

(b) Patient survival rates; and

(c) Relative cost per case.

(2) A transplant COE shall meet or exceed annually the following applicable volume criteria for the particular transplant procedures performed at the facility, except for cornea transplants which do not have established minimum volume

requirements. Annual volume requirements for transplant centers of excellence include:

(a) Twelve or more heart transplants;

(b) Ten or more lung transplants;

(c) Ten or more heart-lung transplants;

(d) Twelve or more liver transplants;

(e) Twenty-five or more kidney transplants;

(f) Eighteen or more pancreas transplants;

(g) Eighteen or more kidney-pancreas transplants;

(h) Ten or more bone marrow transplants; and

(i) Ten or more peripheral stem cell (PSC) transplants.

Dual-organ procedures may be counted once under each organ and the combined procedure.

(3) A transplant facility within the state that fails to meet the volume requirements in subsection (1) of this section may submit a written request to the department for conditional approval as a transplant center of excellence. The department shall consider the minimum volume requirement met when the requestor submits an approved certificate of need for transplant services from the state department of health.

(4) An in-state facility granted conditional approval by the department as a transplant center of excellence shall meet the department's criteria, as established in this chapter, within one year of the conditional approval. The department shall automatically revoke such conditional approval for any facility which fails to meet the department's published criteria within the allotted one year period, unless:

(a) The facility submits a written request for extension of the conditional approval thirty calendar days prior to the expiration date; and

(b) Such request is granted by the department.

(5) A transplant center of excellence shall meet Medicare's survival rate requirements for the transplant procedure(s) performed at the facility.

(6) A transplant center of excellence shall submit to the department annually, at the same time the hospital submits a copy of its Medicare Cost Report (HCFA 2552 report) documentation showing:

(a) The numbers of transplants performed at the facility during its preceding fiscal year, by type of procedure; and

(b) Survival rates data for procedures performed over the preceding three years as reported on the United Network of Organ Sharing report form.

(7)(a) Transplant facilities shall submit to the department, within sixty days of the date of the facility's approval as a center of excellence, a complete set of the comprehensive patient selection criteria and treatment protocols used by the facility for each transplant procedure it has been approved to perform.

(b) The facility shall submit to the department updates to said documents annually thereafter, or whenever the facility makes a change to the criteria and/or protocols.

(c) If no changes occurred during a reporting period the facility shall so notify the department to this effect.

(8) The department shall evaluate compliance with the provisions of WAC 388-550-2100 (2)(d) and (e) based on the protocols and criteria submitted to the department by transplant centers of excellence in accordance with subsection (7) of this section. The department shall terminate a facility's

designation as a transplant center of excellence if a review or audit finds that facility in noncompliance with:

(a) Its protocols and criteria in evaluating and selecting candidates for transplantation; and

(b) Distributing donated organs in a fair and equitable manner that promotes an optimal or successful patient outcome.

(9)(a) The department shall provide transplant centers of excellence it finds in noncompliance with subsection (8) of this section sixty days within which such centers may submit a plan to correct a breach of compliance;

(b) The department shall not allow the sixty-day option as stated in (a) of this subsection for a breach that constitutes a danger to the health and safety of clients as stated in WAC 388-87-005 (3)(d);

(c) Within six months of submitting a plan to correct a breach of compliance, a center shall report to the department showing:

(i) The breach of compliance has been corrected; or

(ii) Measurable and significant improvement toward correcting such breach of compliance.

(10) The department shall periodically review the list of approved transplant centers of excellence. The department may limit the number of facilities it designates as transplant centers of excellence or contracts with to provide services to medical care clients if, in the department's opinion, doing so would promote better client outcomes and cost efficiencies.

(11) The department shall reimburse department-approved centers of excellence for covered transplant procedures using any of the methods identified in chapter 388-550 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2300 Payment—PM&R. (1) The department may pay for acute inpatient physical medicine and rehabilitation (PM&R) evaluation and individualized treatment for a client for a period of up to four weeks when all of the following conditions are met:

(a) The client suffers from severe disabilities including, but not limited to, motor and/or cognitive deficits;

(b) The client's condition is of hospital-level acuity and:

(i) The condition is medically stable;

(ii) The client is able to actively participate in rehabilitation at least three hours per day, five days per week;

(iii) The client is alert, cooperative, and follows commands;

(iv) The client can mobilize out of bed;

(v) The client is ready to participate in rehabilitation; and

(vi) The client must have new deficits or recent loss of his/her previous level of function.

(c) The client must show an impairment in two or more of the following areas:

(i) Mobility and strength;

(ii) Self care/activities of daily living (ADLs);

(iii) Communication;

(iv) Continence, evacuation of bowel and/or bladder;

(v) Kitchen/food preparation, safety and skill;

(vi) Cognitive perceptual functioning; or

(vii) Pathfinding skills and safety.

(d) PM&R treatment would potentially enable the client to obtain a greater degree of self-care and/or independence;

(e) The client's medical condition requires that intensive PM&R services be provided in an inpatient setting;

(f) The department authorizes services; and

(g) The services are provided in a contract facility approved by the department to provide inpatient PM&R services.

(2) The department shall pay a hospital admitting a PM&R client who does not meet the above criteria the administrative day rate set at the statewide average daily nursing home rate as determined by the department.

(3) The department may authorize an extension to the inpatient treatment period specified in subsection (1) of this section if the PM&R facility submits adequate written medical justification to the department prior to the expiration of the initial approved stay.

(4) The department shall consider only written applications from facilities requesting designation as approved contract facilities for inpatient PM&R services. To be an inpatient PM&R contract facility, a hospital shall be a commission on accreditation of rehabilitation facilities (CARF)-approved level I or level II rehabilitation facility, as approved by the department.

(5) The department may approve a skilled nursing facility or a hospital as a level II PM&R contract inpatient rehabilitation facility if it meets the following criteria. The skilled nursing facility is:

(a) Medicare and Medicaid-certified;

(b) Accredited by the CARF. The facility shall submit to the department documentation showing its CARF accreditation; and

(c) In good standing with the department.

(6) The department may conditionally approve an inpatient rehabilitation facility as a level II PM&R contract rehabilitation facility if it meets the criteria in subsections (5)(a) and (c) above, and provides documentation showing it:

(a) Is actively operating under CARF standards; and

(b) Has begun the process of obtaining full CARF accreditation.

(7) An inpatient rehabilitation facility conditionally approved as a level II contract rehabilitation facility shall obtain full CARF accreditation within twelve months of being granted conditional approval by the department. The department shall automatically revoke conditional approval for any facility which fails to obtain full CARF accreditation within the allotted one year period.

(8) The department shall determine the most appropriate acute inpatient PM&R facility (inpatient hospital or skilled nursing facility) placement which provides clients the least restrictive environment at the least cost to the department.

(9) A level I PM&R contract rehabilitation facility shall be reimbursed by the department according to the individual hospital's current ratio of cost-to-charge, as described in WAC 388-550-4500.

(10)(a) The department shall reimburse an approved level II PM&R contract rehabilitation facility, whether a hospital or skilled nursing facility, according to the all-inclusive contracted reimbursement allowance, except that such allow-

ance shall not be deemed to include customized adaptive appliances or specialized therapeutic bed, wheelchair, ventilator, or orthotics for home use.

(b) Reimbursement for other medical services provided by the facility which are unrelated to the client's PM&R stay shall be determined by the department on a case-by-case basis.

(11) A hospital not approved by the department as a contract PM&R facility may be reimbursed under the diagnosis-related group methodology, using the initial admitting diagnosis, for rehabilitation services it provides to medical assistance clients.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2400 Chronic pain management program. (1)(a) The department shall cover inpatient chronic pain management training to assist eligible clients to manage chronic pain.

(b) The department shall pay for only one inpatient hospital stay, up to a maximum of twenty-one days, for chronic pain management training per eligible client's lifetime.

(c) Refer to WAC 388-550-1700 (2)(i) and 388-550-1800 for prior authorization.

(2) The department shall reimburse approved chronic pain management facilities an all-inclusive per diem facility fee under the revenue code published in the department's chronic pain management fee schedule. MAA shall reimburse professional fees for chronic pain management services to performing providers in accordance with the department's fee schedule.

(3) The department shall not reimburse a contract facility for unrelated services provided during the client's inpatient stay for chronic pain management, unless the facility requested and received prior approval from the department for those services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2500 Inpatient hospice services. (1) The department shall reimburse hospice agencies participating in the medical assistance program for general inpatient and inpatient respite services provided to clients in hospice care, when:

(a) The hospice agency coordinates the provision of such inpatient services; and

(b) Such services are related to the medical condition for which the client sought hospice care.

(2) Hospice agencies shall bill the department for their services using revenue codes. The department shall reimburse hospice providers a set per diem fee according to the type of care provided to the client on a daily basis.

(3) The department shall reimburse hospital providers directly pursuant to this chapter for inpatient care provided to clients in the hospice program for medical conditions not related to their terminal illness.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2600 Inpatient psychiatric services. For psychiatric hospitalizations, including involuntary admissions, see chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2700 Substance abuse detoxification services. For hospital-based alcohol and/or drug detoxification services, see chapter 246-326 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2750 Hospital discharge planning services. For discharge planning service requirements, see chapter 246-318 WAC.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2750, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2800 Establishing inpatient payment rates. (1) Inpatient hospital services shall be reimbursed using the methodologies identified by the department in its approved state plan. In determining a hospital's basic payment rate, the department shall use either:

(a) A negotiated conversion factor, for hospitals participating in the federally waivered Medicaid hospital selective contracting program;

(b) A cost-based conversion factor, for hospitals not located in selective contracting areas and for hospitals and/or services exempt from selective contracting; or

(c) The ratio of cost to charge, for hospitals and services exempt from conversion factor-based payment methods, as described in WAC 388-550-4200 and WAC 388-550-4300.

(2) As required by 42 CFR § 447.271, the department's total annual aggregate Medicaid payments to each hospital for inpatient hospital services provided to Medicaid clients shall not exceed the hospital's customary charges to the general public for the services. The department will recoup amounts of total annual aggregate Medicaid payments in excess of such charges.

(3) The department's annual aggregate payments for inpatient hospital services, including annual aggregate payments to state-operated hospitals, shall not exceed amounts that can reasonably be estimated would have been paid under the Medicare payment principles.

(4) Reimbursement to a hospital shall not increase by more than the amount allowed under 42 U.S.C. Section 1385x (v)(1)(O) as a result of a change of ownership.

(5) Hospitals participating in the medical assistance program shall submit annually to the department:

(a) A copy of their HCFA 2552 uniform cost report; and

(b) A disproportionate share hospital application with the department. Participating providers shall permit the department to conduct periodic audits of their financial and statistical records.

(6) The reports referred to in subsection (5) of this section shall be completed in accordance with Medicare cost reporting requirements, the provisions of this chapter, and such instructions as may be issued by the department from

time to time. Unless federally or state-regulated or instructed by the department, providers shall follow generally accepted accounting principles.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-2900 Payment limits—Inpatient hospital services. (1) The department shall pay covered inpatient hospital services only to:

(a) General hospitals that meet the definition in RCW 70.41.020;

(b) Inpatient psychiatric facilities and alcohol or drug treatment centers approved by the department; and

(c) Out-of-state hospital providers subject to conditions specified in WAC 388-550-6700.

(2) The department shall not pay for hospital care and/or services provided to a client enrolled with a department-contracted managed care carrier, unless the medical assistance administration (MAA) specifically authorized the provision of and payment for a service not covered by the health carrier's capitation contract with the department but covered under the client's medical assistance program.

(3) The department shall not pay a hospital for care or services provided to a client enrolled in the hospice program, except as provided under WAC 388-550-2500(3).

(4) The department shall not pay hospitals for inpatient ancillary services in addition to the diagnosis-related group (DRG) payment. The DRG payment includes ancillary services which include, but are not limited to, the following:

(a) Laboratory services;

(b) Diagnostic X-ray and other imaging services, including, but not limited to, magnetic resonance imaging, magnetic resonance angiography, computerized axial tomography, and ultrasound;

(c) Drugs and pharmacy services;

(d) Respiratory therapy and related services;

(e) Physical therapy and related services;

(f) Occupational therapy;

(g) Speech therapy and related services;

(h) Durable medical equipment and medical supplies, including infusion equipment and supplies;

(i) Prosthetic devices used during the client's hospital stay or permanently implanted during the hospital stay, such as artificial heart or replacement hip joints; and

(j) Service charges for handling and processing blood or blood derivatives.

(5) Neither the department nor the client shall be responsible for payment for additional days of hospitalization when:

(a) A client exceeds the professional activities study (PAS) length of stay (LOS) limitations; and

(b) The provider has not obtained department approval for the LOS extension, as specified in WAC 388-550-1700 (3)(a).

(6) The LOS limit for a hospitalization shall be the seventy-fifth percentile of the PAS length of stay for that diagnosis code or combination of codes, published in the PAS Length of Stay-Western Region edition, as periodically updated.

(7) Neither the department nor the client shall be responsible for payment of elective or nonemergent inpatient services included in the department's selective contracting program and received in a nonparticipating hospital in a selective contracting area (SCA) unless the provider received prior approval from the department as required by WAC 388-550-1700 (2)(a). The client, however, may be held responsible for payment of such services if he or she contracts in writing with the hospital at least seventy-two hours in advance of the hospital admission to be responsible for payment. See WAC 388-550-4600, Selective contracting program.

(8) The department shall consider hospital stays of twenty-four hours or less short stays, and shall not pay such stays under the DRG methodology, except that stays of twenty-four hours or less involving the following situations shall be paid under the DRG system:

(a) Death of a client;

(b) Obstetrical delivery;

(c) Initial care of a newborn; or

(d) Transfer of a client to another acute care hospital.

(9)(a) Under the ratio of costs-to-charge (RCC) method, the department shall not pay for inpatient hospital services provided more than one day prior to the date of a scheduled or elective surgery, nor shall these services be charged to the client.

(b) Under the DRG method, the department shall deem all services provided prior to the day before a scheduled or elective surgery included in the hospital's DRG payment for the case.

(c) The department shall not count toward the threshold for hospital outlier status:

(i) Any charges for extra days of inpatient stay prior to a scheduled or elective surgery; and

(ii) The associated services provided during those extra days.

(10) The department shall apply the following rules to RCC cases and high-cost DRG outlier cases for costs over the high-cost outlier threshold:

(a) The department shall pay hospitals for accommodation costs at the multiple occupancy rate even when a private room is provided to the client. The department shall pay accommodation costs at the semi-private or ward room rate, consistent with the type of accommodations provided.

(b) The department shall cover hospital stat charges only for specific laboratory procedures determined and published by the department as qualified stat procedures. The department shall not automatically treat tests generated in the emergency room as justifying a stat order.

(c) The department shall reimburse hospitals for special care charges only when:

(i) The hospital has a department of health (DOH) or Medicare-qualified special care unit;

(ii) The special care service being billed, such as intensive care, coronary care, burn unit, psychiatric intensive care, or other special care, was provided in the special care unit;

(iii) The special care service provided is the kind of service for which the special care unit has been DOH- or Medicare-qualified; and

(iv) The client's medical condition required the care be provided in the special care unit.

(11) The department shall determine its actual payment for a hospital admission by deducting from the basic hospital payment those charges which are the client's responsibility, referred to as spend-down, or a third party's liability.

(12) The department shall reduce reimbursement rates to hospitals for services provided to MI/medical care services clients according to the individual hospital's ratable and/or equivalency factors, as provided in WAC 388-550-4800.

(13) The department shall pay for the hospitalization of a client who is eligible for Medicare and Medicaid only when the client has exhausted his or her Medicare part A benefits, including the nonrenewable lifetime hospitalization reserve of sixty days.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-2900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3000 DRG payment system. (1) Except where otherwise specified, the department shall use the diagnosis-related group (DRG) system, which categorizes patients into clinically coherent and homogenous groups with respect to resource use, as the reimbursement method for inpatient hospital services.

(2) The department shall periodically evaluate which all-patient grouper (AP-DRG) version to use.

(3)(a) The department shall calculate the DRG payment for a particular hospital by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, for that admission by the hospital's cost-based conversion factor, as determined in WAC 388-550-3450.

(b) If the hospital is participating in the selective contracting program, the department shall multiply the DRG relative weight for the admission by the hospital's negotiated conversion factor, as specified in WAC 388-550-4600(4).

(4)(a) The department shall pay for a hospital readmission within seven days of discharge for the same client when department review concludes the readmission did not occur as a result of premature hospital discharge.

(b) When a client is readmitted to the same hospital within seven days of discharge, and department review concludes the readmission resulted from premature hospital discharge, the department shall treat the previous and subsequent admissions as one hospital stay and pay a single DRG for the combined stay.

(5) If two different DRG assignments are involved in a readmission as described in subsection (4) of this section, the department shall review the hospital's records to determine the appropriate reimbursement.

(6) The department shall recognize Medicare's DRG payment for a Medicare-Medicaid dually eligible client to be payment in full.

(a) The department shall pay the Medicare deductible and co-insurance related to the inpatient hospital services provided to clients eligible for Medicare and Medicaid.

(b) The department shall ensure total Medicare and Medicaid payments to a provider for such client does not exceed Medicare's maximum allowable charges.

(c) The department shall pay for those allowed charges beyond the threshold using the outlier policy described in WAC 388-550-3700 in cases where:

(i) Such client's Medicare part A benefits including lifetime reserve days are exhausted; and

(ii) The Medicaid outlier threshold status is reached.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3100 Calculating DRG relative weights. (1) The department shall set Washington Medicaid-specific diagnosis-related group (DRG) relative weights, as follows:

(a) The department shall classify Washington Medicaid hospital admissions data and the hospital admissions data in the Washington state department of health's comprehensive hospital abstract reporting system (CHARS), using the all-patient grouper (AP-DRG).

(b) The department shall test each DRG statistically for adequacy of sample size to ensure that relative weights meet acceptable reliability and validity standards.

(c) The department shall establish relative weights from Washington Medicaid hospital admissions data. These relative weights may be stable or unstable.

(d) The department shall establish relative weights from CHARS-derived data which include Medicaid data. These relative weights may be stable or unstable.

(e) The department shall test the stability of Washington Medicaid relative weights established in subsection (1)(c) of this section using the null hypothesis test at seventy-five percent confidence interval. The department shall accept as stable and adopt those Washington Medicaid relative weights that pass the null hypothesis test.

(f) The department shall test the stability of CHARS-derived relative weights established in subsection (1)(d) of this section using the same procedure as in subsection (e) of this section. The department shall replace unstable Washington Medicaid relative weights with stable CHARS-derived relative weights.

(g) The department shall replace remaining unstable Washington Medicaid relative weights with New York proxy relative weights. For the purposes of this chapter, remaining unstable Washington Medicaid relative weights are those that fail the null hypothesis test and for which there are no stable CHARS-derived relative weight replacements.

(2) Using ratios with a Washington Medicaid relative weight as base, the department shall:

(a) Standardize the relative weights by adjusting the CHARS and New York proxy relative weights; and

(b) Assure all Medicaid stable and proxy weights equal a statement case mix of 1.0.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3150 Base period costs and claims data. (1) The department shall set a hospital's cost-based conversion factor using base period cost data from its Medicare cost report (Form HCFA 2552) for its fiscal year corresponding with the base period.

(2) The department shall use in rate-setting only base period cost data that have been desk reviewed and/or field audited by the Medicare intermediary.

(3) The department shall, to the extent feasible, factor out of a hospital's base period cost data nonallowable hospital charges associated with the items/services listed in WAC 388-550-1600(1) before calculating the hospital's conversion factor.

(4) The department shall use the figures for total costs, capital costs, and direct medical education costs from a hospital's HCFA 2552 report in calculating that hospital's allowable costs for each of the thirty-eight categories of cost/revenue centers, listed in subsections (5) and (6) below, used to categorize Medicaid claims.

(5) The department shall use nine categories to assign a hospital's accommodation costs and days of care. These accommodation categories are:

- (a) Routine;
- (b) Intensive care;
- (c) Intensive care-psychiatric;
- (d) Coronary care;
- (e) Nursery;
- (f) Neonatal intensive care unit;
- (g) Alcohol/substance abuse;
- (h) Psychiatric; and
- (i) Oncology.

(6) The department shall use twenty-nine categories to assign ancillary costs and charges. These ancillary categories are:

- (a) Operating room;
- (b) Recovery room;
- (c) Delivery/labor room;
- (d) Anesthesiology;
- (e) Radiology-diagnostic;
- (f) Radiology-therapeutic;
- (g) Radioisotope;
- (h) Laboratory;
- (i) Blood storage;
- (j) Intravenous therapy;
- (k) Respiratory therapy;
- (l) Physical therapy;
- (m) Occupational therapy;
- (n) Speech pathology;
- (o) Electrocardiography;
- (p) Electroencephalography;
- (q) Medical supplies;

- (r) Drugs;
- (s) Renal dialysis;
- (t) Ancillary oncology;
- (u) Cardiology;
- (v) Ambulatory surgery;

(w) Computerized tomography scan/magnetic resonance imaging;

- (x) Clinic;
- (y) Emergency;
- (z) Ultrasound;
- (aa) Neonatal intensive care unit transportation;
- (bb) Gastrointestinal laboratory; and
- (cc) Miscellaneous.

(7) The department shall:

(a) Extract from the Medicaid Management Information System all Medicaid paid claims data for each hospital's base year;

(b) Assign line item charges from the paid hospital claims to the appropriate accommodation and ancillary cost center categories; and

(c) Use the cost center categories to apportion Medicaid costs.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3200 Medicaid cost proxies. (1) For cases in which a hospital has Medicaid charges (claims) for certain accommodation or ancillary cost centers which are not separately reported on its Medicare cost report, the department shall establish cost proxies to estimate such costs in order to ensure recognition of Medicaid related costs.

(2) The department shall develop per diem proxies for accommodation cost centers using the median value of the hospital's per diem cost data within the affected hospital peer group.

(3) The department shall develop ratio of cost-to-charge (RCC) proxies for ancillary cost centers using the median value of the hospital's RCC data within the affected hospital peer group.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3250 Indirect medical education costs. (1) For a hospital with a graduate medical education program, the department shall remove indirect medical education-related costs from the aggregate operating and capital costs of each hospital in the peer group before calculating a peer group's cost cap.

(2) To arrive at indirect medical education costs for each component, the department shall:

(a) Multiply Medicare's indirect cost factor of 0.579 by the ratio of the number of interns and residents in the hospital's approved teaching programs to the number of hospital beds; and

(b) Multiply the product obtained in subsection (2)(a) of this section by the hospital's operating and capital components.

(3) After the peer group's cost cap has been calculated, the department shall add back to the hospital's aggregate costs its indirect medical education costs. See WAC 388-550-3450(6).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3300 Hospital peer groups and cost caps. (1) For rate-setting purposes the department shall group hospitals into peer groups and establish cost caps for each peer group. The department shall set hospital reimbursement rates at levels that recognize the cost of reasonable, efficient, and effective providers.

(2) The department shall use the Washington state department of health's (DOH) four hospital peer groupings for rate-setting purposes. The four peer groups are:

- (a) Group A, rural hospitals;
- (b) Group B, urban hospitals without medical education programs;
- (c) Group C, urban hospitals with medical education program; and
- (d) Group D, specialty hospitals or other hospitals not easily assignable to the other three groups.

(3) The department shall use a cost cap at the seventieth percentile for a peer group.

(a) The department shall cap at the seventieth percentile the costs of hospitals in peer groups B and C whose costs exceed the seventieth percentile for their peer group.

(b) The department shall exempt peer group A hospitals from the cost cap because they are paid under the ratio of cost-to-charge methodology.

(c) The department shall exempt peer group D hospitals from the cost cap because they are specialty hospitals without a common peer group on which to base comparisons.

(4) The department shall calculate a peer group's cost cap based on the hospitals' base period cost after subtracting:

(a) Indirect medical education costs, as determined in WAC 388-550-3250(2), from the aggregate operating and capital costs of each hospital in the peer group; and

(b) The cost of outlier cases from the aggregate costs in accordance with WAC 388-550-3350(1).

(5)(a) The department shall use the lesser of each individual hospital's calculated aggregate cost or the peer group's seventieth percentile cost cap as the base amount in calculating the individual hospital's adjusted cost-based conversion factor.

(b) After the peer group cost cap is calculated, the department shall add back to the individual hospital's base amount its indirect medical education costs and appropriate outlier costs, as determined in WAC 388-550-3350(2).

(6) The department shall recognize in its rate-setting process changes in peer group status as a result of DOH approval or recommendation. However, in cases where corrections or changes in individual hospitals' base-year cost or peer group assignment occur after peer group cost caps are calculated, the department shall update the peer group cost caps involved only if the change in the individual hospital's base-year cost or peer group assignment would result in a five percent or greater change in the seventieth percentile of costs calculated for its peer group.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3350 Outlier costs. (1)(a) The department shall remove the cost of low- and high-cost outlier cases from individual hospitals' aggregate costs before calculating the peer group cost cap.

(b) After this initial step, all subsequent calculations involving outliers in subsections (2) through (5) of this section pertain only to high-cost outliers.

(c) For a definition of outliers see WAC 388-550-1050, Definitions.

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(2) After an individual hospital's base period costs and its peer group cost cap are determined, the department shall add the individual hospital's indirect medical education costs and an outlier cost adjustment back to:

(a) The lesser of the hospital's calculated aggregate cost; or

(b) The peer group's seventieth percentile cost cap.

(3) The outlier cost adjustment is determined as follows to reduce the original high-cost outlier amount in proportion to the reduction in the hospital's base period costs as a result of the capping process:

(a) If the individual hospital's aggregate operating, capital, and direct medical education costs for the base period are less than the seventieth percentile costs for the peer group, the entire high-cost outlier amount is added back.

(b) A reduced high-cost outlier amount is added back if:

(i) The individual hospital's aggregate base period costs are higher than the seventieth percentile for the peer group; and

(ii) The hospital is capped at the seventieth percentile.

(iii) The amount of the outlier added back is determined by multiplying the original high-cost outlier amount by the percentage obtained when the hospital's final cost cap, which is the peer group's seventieth percentile cost, is divided by its uncapped base period costs, as determined in WAC 388-550-3300(4).

(4) The department shall pay high-cost outlier claims from the outlier set-aside pool. The department shall calculate an individual hospital's high-cost outlier set-aside as follows:

(a) For each hospital, the department extracts utilization and paid claims data from the Medicaid Management Information System (MMIS) for the most recent twelve-month period for which the department estimates the MMIS has complete payment information.

(b) Using the data in (a) of this subsection, the department determines the projected annual amount above the high-cost DRG outlier threshold that the department paid to each hospital.

(c) The department's projected high-cost outlier payment to the hospital determined in (b) of this subsection is divided by the department's total projected annual DRG payments to the hospital to arrive at a hospital-specific high-cost outlier percentage. This percentage becomes the hospital's outlier set-aside factor.

(5) The department shall use the individual hospital's outlier set-aside factor to reduce the hospital's CBCF by an amount that goes into a set-aside pool to pay for all high-cost outlier cases during the year. The department shall fund the outlier set-aside pool on hospitals' prior high-cost outlier experience. No cost settlements shall be made to hospitals for outlier cases.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3400 Case-mix index. (1)(a) The department shall adjust hospital costs for case mix under the diagnosis-related group (DRG) payment systems.

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(b) The department shall calculate a case-mix index (CMI) for each individual hospital to measure the relative cost for treating Medicaid cases in a given hospital.

(2) The department shall calculate the CMI for each hospital using Medicaid admissions data from the individual hospital's base period cost report, as described in WAC 388-550-3150. The hospital-specific CMI is calculated as follows:

(a) The department shall multiply the number of Medicaid admissions to the hospital for a specific DRG by the relative weight for that DRG. The department shall repeat this process for each DRG billed by the hospital.

(b) The department shall add together the products in (a) of this subsection for all of the Medicaid admissions to the hospital in the base year.

(c) The department shall divide the sum obtained in (b) of this subsection by the corresponding number of Medicaid hospital admissions.

(d) Example: If the average case mix index for a group of hospitals is 1.0, a CMI of 1.0 or greater for a hospital in that group means that the hospital has treated a mix of patients in the more costly DRGs. A CMI of less than 1.0 indicates a mix of patients in the less costly DRGs.

(3) The department shall recalculate each hospital's case mix index periodically, but no less frequently than each time rebasing is done.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3450 Payment method—CBCF rate calculation. (1)(a) The department shall use each hospital's base period cost data to calculate the hospital's total operating, capital, and direct medical education costs for each of the nine accommodation categories described in WAC 388-550-3150(5).

(b) The department shall divide operating, capital, and direct medical education costs by total hospital days per category to arrive at a per day accommodation cost.

(c) The department shall multiply the per day accommodation cost by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

(2)(a) The department shall also use the base period cost data to calculate total operating, capital and direct medical education costs for each of the hospital's twenty-nine ancillary categories.

(b) The department shall divide these costs by total charges per category to arrive at a cost-to-charge ratio per ancillary category.

(c) The department shall multiply these cost-to-charge ratios by Medicaid charges per category, as tracked by the Medicaid Management Information System (MMIS), to arrive at total Medicaid ancillary costs per category for the three components.

(3) The department shall combine Medicaid accommodation and ancillary costs to derive the hospital's operating, capital and direct medical education components for the base year. The department shall divide these components' combined total will be divided by the number of Medicaid cases

during the base year to arrive at an average cost per DRG admission for the hospital.

(4) The department shall adjust the average cost per admission for each component to a common fiscal year end using the appropriate McGraw-Hill Data Resources, Inc., (DRI) Prospective Payment System (PPS)-Type Hospital Market Basket update. The department shall standardize these three admission cost components by dividing the average cost by the hospital's case-mix index.

(5)(a) For hospitals with medical education programs, the department shall remove the indirect medical education costs from operating and capital costs before the peer group cost cap is set.

(b) The department shall also remove the cost of outlier cases in accordance with WAC 388-550-3350(1).

(c) For hospitals in peer group B and C, the department shall set aggregate costs for the operating, capital, and direct medical education components at the lesser of hospital-specific aggregate cost or the peer group cost cap.

(6) The department shall add to the lesser of the hospital-specific aggregate cost or the peer group cost cap determined in subsection (5) of this section:

(a) The individual hospital's indirect medical education costs, as determined in WAC 388-550-3250(2); and

(b) An outlier cost adjustment in accordance with WAC 388-550-3350(2).

(7)(a) The department shall multiply the sum obtained in subsection (6) of this section by the DRI PPS-type hospital market basket update for the period January 1 of the year after the base year through September 30 of the rebase year.

(b) The department shall then reduce the product obtained in (a) of this subsection by the outlier set-aside percentage determined in accordance with WAC 388-550-3350(3) to arrive at the hospital's adjusted cost-based conversion factor for July 1 of the rebase year.

(8) The department shall multiply the hospital's adjusted cost-based conversion factor determined in subsection (7) of this section by the applicable DRG relative weight to calculate the DRG payment for each admission.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3450, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3500 Inflation adjustments. (1) Effective on October 1 of each year, the department shall adjust all cost-based conversion factors for inflation for the federal fiscal year October 1 through September 30.

(2) The department shall use as annual inflation factor the prospective payment system (PPS)-type hospital market-basket index factor from the most recent McGraw-Hill Data Resources, Inc., (DRI) forecast.

(3) The department shall consider adjustments to negotiated conversion factors according to the terms of the individual hospital's contract.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3600 Payment—Hospital transfers. The department shall apply the following payment rules when a client is transferred from one hospital to another:

(1) The department shall deny payment to a hospital that transfers a nonemergent case to another hospital without the department's prior approval.

(2) The department shall pay a hospital transferring a client to another acute care hospital the lesser of:

(a) A per diem rate multiplied by the number of medically necessary days at the transferring hospital. The department shall determine the per diem rate by dividing the hospital's diagnosis-related group (DRG) payment amount for the appropriate DRG by that DRG's average length of stay; or

(b) The appropriate DRG payment.

(3) The department shall use the hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer. The department shall use the medical assistance administration's length of stay data to determine the number of medically necessary days for a hospital stay.

(4) The department shall pay the hospital that ultimately discharges the client to any residence other than a hospital (e.g., home, nursing facility, etc.) the full DRG payment. The department shall apply the outlier payment methodology if a transfer case qualifies as a high- or low-cost outlier.

(5) The department shall not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital which subsequently sends the client back to the original hospital from which the client is discharged.

(6)(a) The extent of the department's payment to the discharging hospital shall be the full DRG payment.

(b) The department shall pay the intervening hospital a per diem payment based on the method described in subsection (2) of this section.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3700 DRG outliers and administrative day rates. (1) The department shall calculate high-cost diagnosis-related group (DRG) outlier payments for qualifying cases as follows:

(a) To qualify as a DRG high-cost outlier, the allowed charges for the case must exceed a threshold of three times the applicable DRG payment or twenty-eight thousand dollars, whichever is greater.

(b) Reimbursement for high-cost outlier cases other than those in subsections (1)(c) and (d) of this section shall be the applicable DRG payment amount, plus seventy-five percent of the hospital's ratio of cost-to-charge (RCC) ratio applied to the allowed charges exceeding the outlier threshold.

(c) Reimbursement for psychiatric high-cost outliers for DRGs 424-432 shall be at the applicable DRG rate plus hundred percent of the hospital RCC applied to the allowed charges exceeding the outlier threshold.

(d) Reimbursement for high-cost outlier cases at in-state children's hospitals shall be the applicable DRG payment amount, plus eighty-five percent of the hospital's RCC

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applied to the allowed charges exceeding the outlier threshold.

(2) The department shall calculate low-cost DRG outlier payments for qualifying cases as follows:

(a) To qualify as a DRG low-cost outlier, the allowed charges for the case shall be less than or equal to ten percent of the applicable DRG payment or four hundred dollars, whichever is greater.

(b) The department's reimbursement for low-cost DRG outlier claims shall be the allowed charges multiplied by the hospital's RCC.

(3) The department shall pay hospitals an all-inclusive administrative day rate for those days of hospital stay in which a client no longer needs an acute inpatient level of care, but is not discharged because an appropriate noninpatient hospital placement is not available.

(a) The department shall set reimbursement for administrative days at the statewide average Medicaid nursing facility per diem rate. The administrative day rate shall be adjusted annually effective October 1.

(b) Ancillary services shall not be reimbursed during administrative days.

(c) For a DRG payment case, the department shall not pay administrative days until the case exceeds the high-cost outlier threshold for that case.

(d) For DRG-exempt cases, the department shall identify administrative days during the length of stay review process after the client's discharge from the hospital.

(e) If the hospital admission is solely for a stay until an appropriate sub-acute placement can be made, the department shall reimburse the hospital at the administrative day per diem rate from the date of admission.

(4) The department shall make day outlier payments to hospitals, in accordance with section 1923 (a)(2)(C) of the Social Security Act, for exceptionally long-stay clients. A hospital shall be eligible for the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share (DSH) hospital and the client served is under the age of six, or the hospital may not be a DSH hospital but the client served is a child under age one;

(b) The payment methodology for the admission is DRG;

(c) The charge for the hospitalization is below the high-cost outlier threshold (three times the DRG rate or twenty-eight thousand dollars, whichever is greater); and

(d) The client's length of stay is over the day outlier threshold for the applicable DRG. The day outlier threshold is defined as the number of an average length of stay for a discharge (for an applicable DRG), plus twenty days.

(5) The department shall base the day outlier payment on the number of days exceeding the day outlier threshold, multiplied by the administrative day rate.

(6) The department's total reimbursement for day outlier claims shall be the applicable DRG payment plus the day outlier or administrative days payment.

(7) Day outliers shall only be paid for cases that do not reach high-cost outlier status. A client's claim shall be either a day outlier or a high-cost outlier, but not both.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3800 Rebasing and recalibration. (1) The department shall rebase the Medicaid payment system periodically using each hospital's cost report for its fiscal year that ends during the calendar year designated by the department to be used for each update.

(2) The department shall recalibrate diagnosis-related group weights periodically, as described in WAC 388-550-3100, but no less frequently than each time rebasing is done. The department shall make recalibrated weights effective July 1 of that year.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3900 Border area hospitals payment method. (1) Under the diagnosis-related group (DRG) payment method, the department shall calculate the cost-based conversion factor (CBCF) of a border area hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(a) For a border area hospital with insufficient Medicare cost report (HCFA Form 2552) data, the department shall assign a CBCF based on the peer group average final conversion factor for its Washington hospital peer group.

(b) The department shall include in this average final conversion factor all adjustments to the CBCF, including the outlier set-aside factor described in WAC 388-550-3350(3).

(2) Under the ratio of cost-to-charge (RCC) payment method, the department shall calculate a border area hospital's RCC in accordance with WAC 388-550-4500. For a border area hospital with insufficient Medicare cost report (HCFA Form 2552) data, the department shall assign an RCC based on the weighted average of the RCC ratios for in-state Washington hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4000 Out-of-state hospitals payment method. The department shall pay out-of-state hospitals the lesser of billed charges or the amount calculated using the weighted average of ratio of cost-to-charge ratios for in-state Washington hospitals multiplied by the allowed charges for medically necessary services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4100 New hospitals payment method. (1) For rate-setting purposes, the department shall consider as a new hospital an entity which began services after the most recent base period used for calculating cost-based conversion factors (CBCFs).

(2) The department shall base a new hospital's cost-based rates on the peer group average final conversion factor for its Washington hospital peer group. The department shall include in this average final conversion factor all adjustments

to the CBCF, including the outlier set aside factor described in WAC 388-550-3350(3).

(3) The department shall base a new hospital's ratio of cost-to-charge (RCC) rates on the statewide weighted average RCC rate.

(4) The department shall not consider a change in ownership as constituting creation of a new hospital.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4200 Change in hospital ownership.

(1) For purposes of this section, a change in hospital ownership may involve one or more, but is not limited to, the following events:

(a) A change in the composition of the partnership;

(b) A sale of an unincorporated sole proprietorship;

(c) The statutory merger or consolidation of two or more corporations;

(d) The leasing of all or part of a provider's facility if the leasing affects utilization, licensure, or certification of the provider entity;

(e) The transfer of a government-owned institution to a governmental entity or to a governmental corporation;

(f) Donation of all or part of a provider's facility to another entity if the donation affects licensure or certification of the provider entity;

(g) Disposition of all or some portion of a provider's facility or assets through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity; or

(h) A change in the provider's federal identification tax number.

(2) A hospital shall notify the department in writing ninety days prior to the date of an expected change in the hospital's ownership, but in no case later than thirty days after the change in ownership takes place.

(3) When a change in a hospital's ownership occurs, the department shall set the new provider's cost-based conversion factor (CBCF) at the same level as the prior owner's, except as provided in subsection (4) below.

(4) The department shall set for a hospital formed as a result of a merger:

(a) A blended CBCF based on the old hospitals' rates, proportionately weighted by admissions for the old hospitals; and

(b) An RCC rate determined by combining the old hospitals' cost reports and following the process described in WAC 388-550-4500.

(5) The department shall recapture depreciation and acquisition costs as required by section 1861 (V)(1)(O) of the Social Security Act.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4300 Payment—Exempt hospitals. (1)

The department shall exempt the following hospitals from the diagnosis-related group (DRG) payment method:

(a) Peer group A hospitals, as defined in WAC 388-550-3300(2);

(b) Rehabilitation units: Rehabilitation services provided in specifically identified rehabilitation hospitals and designated rehabilitation units of general hospitals. The department shall use the same criteria employed by the Medicare program to identify exempt hospitals and designated distinct part rehabilitation units;

(c) Out-of-state hospitals: Those facilities located outside of Washington and outside designated border areas as described in WAC 388-501-0175. The department shall pay these hospitals according to WAC 388-550-4000; and

(d) Military hospitals: Military hospitals may individually elect to get reimbursed a negotiated per diem rate, or the DRG or RCC reimbursement method. The department shall exempt military hospitals from the DRG payment method if no other specific arrangements have been made.

(2) The department shall limit inpatient hospital stays in hospitals identified in subsection (1) above to the number of days established at the seventy-fifth percentile in the current edition of the publication, "*Length of Stay by Diagnosis and Operation, Western Region*," unless:

(a) The department has a prior arrangement for a specified length of stay; or

(b) The stay is for chemical dependency treatment which is subject to WAC 388-550-1100(3).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4400 Services—Exempt from DRG payment. (1) The department shall exclude the following services from the diagnosis-related group (DRG)-based payment system:

(a) Neonatal services: The department shall exempt DRGs 602-619, 621-628, 630, 635, 637-641 neonatal services from the DRG payment methods. The department shall reimburse DRGs 620 and 629 (normal newborns) by the DRG payment method.

(b) Acquired immunodeficiency syndrome (AIDS)-related inpatient services: AIDS-related inpatient services for those cases with a reported diagnosis of, AIDS-related complex and other human immunodeficiency virus infections.

(c) Alcohol detoxification and treatment services: Alcoholism detoxification and treatment services provided in department-approved alcohol treatment centers.

(d) Detoxification, medical stabilization, and drug treatment for chemically-dependent pregnant women: Hospital-based intensive inpatient care for detoxification, medical stabilization, and drug treatment provided to chemically-dependent pregnant women by a certified hospital.

(e) Physical medicine and rehabilitation: Rehabilitation services provided in department-approved rehabilitation hospitals and general hospital distinct units, and services for physical medicine and rehabilitation patients.

(f) Chronic pain management: Pain management treatment provided in department-approved pain treatment facilities.

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(g) Inpatient services for managed care plan enrollees: The department shall reimburse hospitals for these enrollees according to the contract between the hospital and the managed care plan.

(h) Long-term care administrative day services: The department shall reimburse long-term care services based on the statewide average Medicaid nursing facility per diem rate, which is adjusted annually each October 1. The department shall apply this rate to patient days identified as administrative days on the hospital's notice of rates. Hospitals must request a long-term care administrative day designation on a case-by-case basis.

(2) Except when otherwise specified, the department shall reimburse hospitals and services exempt from the DRG payment method under the RCC method, as described in WAC 388-550-4500.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4500 Payment method—RCC. (1)(a) The department shall calculate a hospital's ratio of cost to charge (RCC) by dividing allowable operating costs by patient revenues associated with these allowable costs.

(b) The department shall base these figures on the annual Medicare cost report data provided by the hospital.

(c) The department shall update hospitals' RCC ratios annually with the submittal of new HCFA 2552 Medicare cost report data. Prior to computing the ratio, the department shall exclude increases in operating costs or total rate-setting revenue attributable to a change in ownership.

(2) The department shall limit a hospital's RCC to one hundred percent of its allowable charges. The department shall recoup payments made to a hospital in excess of its customary charges to the general public.

(3) The department shall establish the basic hospital payment by multiplying the hospital's assigned RCC ratio by the allowed charges for medically necessary services. The department shall deduct client responsibility (spend-down) or third-party liability (TPL) as identified on the billing invoice or by the department from the basic payment to determine the actual payment due from the department for that hospital admission.

(4) The department shall use the RCC payment method to reimburse:

(a) Peer group A hospitals;

(b) Other DRG-exempt hospitals identified in WAC 388-550-4300; and

(c) Any hospital for DRG-exempt services described in WAC 388-550-4400.

(5) The department shall deem the RCC for in-state and border area hospitals lacking sufficient HCFA 2552 Medicare cost report data the weighted average of the RCC ratios for in-state hospitals.

(6) The department shall calculate an outpatient ratio of cost-to-charge by dividing the projected costs by the projected charge multiplied by the average RCC.

(a) In no case shall the outpatient adjustment factor exceed 1.0.

(b) The factor shall be updated each October 1.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4600 Hospital selective contracting

program. (1) The department shall designate selective contracting areas (SCA) in which hospitals participate in competitive bidding to provide hospital services to medical care clients. Selective contracting areas are based on historical patterns of hospital use by Medicaid clients.

(2) The department shall require medical care clients in a selective contracting area obtain their elective (nonemergent) inpatient hospital services from participating or exempt hospitals in the SCA. Elective (nonemergent) inpatient hospital services provided by nonparticipating hospitals in an SCA shall not be reimbursed by the department, except as provided in WAC 388-550-4700.

(3) The department shall exempt from the selective contracting program those hospitals that are:

(a) In an SCA but designated by the department as remote. The department shall designate as remote hospitals meeting the following criteria:

(i) Located more than ten miles from the nearest hospital in the SCA;

(ii) Having fewer than seventy-five beds; and

(iii) Having fewer than five hundred Medicaid admissions in a two-year period.

(b) Owned by health maintenance organizations (HMOs) and providing inpatient services to HMO enrollees only;

(c) Children's hospitals;

(d) State psychiatric hospitals or separate (freestanding) psychiatric facilities; and

(e) Out-of-state hospitals in nonborder areas, and out-of-state hospitals in border areas not designated as selective contracting areas.

(4)(a) The department shall negotiate with selectively contracted hospitals a negotiated conversion factor (NCF) for inpatient hospital services.

(b) The department shall calculate its maximum financial obligation for a client under the hospital selective contract in the same manner as DRG payments using cost-based conversion factors (CBCFs).

(c) The department shall apply NCFs to Medicaid clients only. The department shall use CBCFs in calculating payments for MI/medical care services clients.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4700 Payment—Non-SCA participating hospitals. (1) In a selective contracting area (SCA), the department shall pay any qualified hospital for inpatient hospital services provided to an eligible medical care client for treatment of an emergency medical condition.

(2) The department shall pay any qualified hospital for medically necessary but nonemergent inpatient hospital services provided to an eligible medical care client deemed by the department to reside an excessive travel distance from a contracting hospital.

(a) The client is deemed to have an excessive travel burden if the travel distance from a client's residence to the nearest

contracting hospital exceeds the client's county travel distance standard, as follows:

<u>County</u>	<u>Community Travel Distance Norm</u>
Adams	25 miles
Asotin	15 miles
Benton	15 miles
Chelan	15 miles
Clallam	20 miles
Clark	15 miles
Columbia	19 miles
Cowlitz	15 miles
Douglas	20 miles
Ferry	27 miles
Franklin	15 miles
Garfield	30 miles
Grant	24 miles
Grays Harbor	23 miles
Island	15 miles
Jefferson	15 miles
King	15 miles
Kitsap	15 miles
Kittitas	18 miles
Klickitat	15 miles
Lewis	15 miles
Lincoln	31 miles
Mason	15 miles
Okanogan	29 miles
Pacific	21 miles
Pend Oreille	25 miles
Pierce	15 miles
San Juan	34 miles
Skagit	15 miles
Skamania	40 miles
Snohomish	15 miles
Spokane	15 miles
Stevens	22 miles
Thurston	15 miles
Wahkiakum	32 miles
Walla Walla	15 miles
Whatcom	15 miles
Whitman	20 miles
Yakima	15 miles

(b) If a client must travel outside his/her SCA to obtain inpatient services not available within the community, such as treatment from a tertiary hospital, the client shall obtain such services from a contracting hospital appropriate to the client's condition.

(3) The department shall require prior authorization for all nonemergent admissions to nonparticipating hospitals in an SCA. See WAC 388-550-1700 (2)(a).

(4) The department shall pay a licensed hospital all applicable Medicare deductible and coinsurance amounts for inpatient services provided to Medicaid clients who are also beneficiaries of Medicare part A.

(5) The department shall pay any licensed hospital DRG-exempt services as listed in WAC 388-550-4400.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4800 Hospital payment method—

State-only programs. (1) (a) The department shall calculate payments to hospitals for state-only MI/medical care services clients according to the:

(i) Diagnosis-related group (DRG); or

(ii) Ratio of cost-to-charge (RCC) methodologies; and

(b) The department shall reduce hospitals' Title XIX rates by their ratable and/or equivalency (EQ) factors, as applicable.

(2) The department shall calculate ratables as follows:

(a) A hospital's Medicare and Medicaid revenues are added together, along with the value of the hospital's charity care and bad debts. The hospital's low-income disproportionate share (LIDSH) revenue is deducted from this total to arrive at the hospital's community care dollars.

(b) Revenue generated by hospital-based physicians, as reported in the hospital's HCFA 2552 report, is subtracted from total hospital revenue, also as reported in the hospital's cost report.

(c) The amount derived in step (2)(a) is divided by the amount derived in step (2)(b) to obtain the ratio of community care dollars to total revenue.

(d) The result of step (2)(c) is subtracted from 1.000 to derive the hospital's ratable. The hospital's Title XIX cost-based conversion factor (CBCF) or RCC rate is multiplied by (1-ratable) for an MI or medical care services client.

(e) The reimbursements for MI/medical care services clients are mathematically represented as follows:

MI/medical care services RCC = Title XIX RCC x (1-Ratable)

MI/medical care services CBCF= Title XIX Conversion Factor x (1-Ratable) x EQ

(3) The department shall update each hospital's ratable annually on July 1.

(4)(a) The department shall use the equivalency factor (EQ) to hold the DRG reimbursement rates for the MI/medical care services programs at their current level prior to any rebasing. The department shall apply the EQ only to the Title XIX DRG CBCFs. The department shall not apply the EQ when the DRG rate change is due to the application of the annual DRI inflation adjustment.

(b) The department shall calculate a hospital's equivalency factor as follows:

EQ= (Current MI/medical care services conversion factor)/(Title XIX DRG rate x (1-ratable))

(5) Effective for hospital admissions on or after December 1, 1991, the department shall reduce its payment for MI (but not medical care services) clients further by multiplying it by ninety-seven percent. The department shall apply this payment reduction adjustment to the MIDSH methodology in accordance with section 3(b) of the "Medicaid Voluntary Contributions and Provider-Specific Tax Amendment of 1991."

(6) When the MI/medical care services client has a trauma severity factor of nine or more, the department shall pay the full Medicaid Title XIX amount when care has been provided in a nongovernmental hospital designated by DOH as a trauma center. The department shall apply the reduction in MI cases where the trauma severity factor is less than nine.

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The department shall give an annual grant to governmental hospitals certified by DOH.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-4900 Disproportionate share payments. (1) As required by section 1902 (a)(13)(A) of the Social Security Act, the department shall give consideration to hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment to eligible hospitals. The department shall deem this adjustment a disproportionate share payment.

(2) The department shall deem a hospital a disproportionate share hospital if:

(a) The hospital's Medicaid inpatient utilization rate (MIPUR), as defined in WAC 388-550-1050, is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state, or its low-income utilization rate (LIUR), as defined in WAC 388-550-1050, exceeds twenty-five percent; and

(b) The hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals, except that this requirement shall not apply to a hospital:

(i) The inpatients of which are predominantly individuals under eighteen years of age; or

(ii) Which did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(3) For hospitals located in rural areas, "obstetrician" shall mean any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(4) The department may define or deem a hospital a disproportionate share hospital if:

(a) The hospital has a Medicaid inpatient utilization rate (MIPUR) of not less than one percent; and

(b) The hospital meets the requirement of subsection (2)(c) of this section.

(5) The department shall administer the following disproportionate share programs:

(a) Low-income disproportionate share hospital;

(b) Medically-indigent disproportionate share hospital;

(c) General assistance-unemployable disproportionate share hospital;

(d) Small rural hospital assistance program disproportionate share hospital;

(e) Teaching hospital assistance program disproportionate share hospital;

(f) State teaching hospital financing program disproportionate share hospital;

(g) County teaching hospital financing program disproportionate share hospital; and

(h) Public hospital district disproportionate share hospital.

(6) The department shall allow a hospital to receive any one or all of the disproportionate share hospital (DSH) payment adjustments discussed in subsection (5) of this section if:

(a) The hospital applies to the department; and

(b) Meets the eligibility requirements for the particular DSH payment program, as discussed in WAC 388-550-5000 through 388-550-5400.

(7) The department shall ensure each hospital's total DSH payments do not exceed the individual hospital's DSH limit, defined as the cost to the hospital of providing services to Medicaid patients, including patients served under Medicaid managed care programs, less the amount paid by the state under the non-DSH payment provision of the state plan, plus the cost to the hospital of providing services to uninsured patients, less any cash payments made by uninsured patients.

(8)(a) The department's total annual DSH payments shall not exceed the state's DSH allotment for the federal fiscal year.

(b) If the DSH statewide allotment is exceeded, the department shall recoup overpayments from hospitals in the following program order:

(i) Public hospital district disproportionate share hospital;

(ii) Teaching hospital assistance program disproportionate share hospital;

(iii) County teaching hospital financing program disproportionate share hospital;

(iv) State teaching hospital financing program disproportionate share hospital;

(v) Small rural hospital assistance program disproportionate share hospital;

(vi) Medically-indigent disproportionate share hospital;

(vii) General assistance-unemployable disproportionate share hospital; and

(viii) Low-income disproportionate share hospital.

(9) The department shall make periodic DSH payments to eligible hospitals. The department shall have sole discretion regarding the timing of DSH payments.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5000 Payment method—LIDSH. (1) The department shall deem a hospital serving the department's clients eligible for a low-income disproportionate share hospital (LIDSH) payment adjustment if the hospital meets the requirements of WAC 388-550-4900(2).

(2) The department shall pay hospitals deemed eligible under the criteria in subsection (1) of this section DSH payment amounts which in total equal the funding set by the state's appropriations act for LIDSH. The amount appropriated for LIDSH may vary from year to year.

(3) The department shall apportion LIDSH payments to individual hospitals as follows:

(a) For each LIDSH-eligible hospital, the department shall determine the standardized Medicaid inpatient utilization rate (MIPUR). The MIPUR is standardized by dividing the hospital's MIPUR by the average MIPUR of all LIDSH-eligible hospitals.

(b) The hospital's standardized MIPUR is multiplied by the hospital's most recent fiscal year case mix index, and then by the hospital's most recent fiscal year Title XIX admissions. The product is then multiplied by an initial random base amount.

(c) The annual LIDSH payment so calculated for individual hospitals shall be added and compared to the appropriated amount. If the amounts differ, a new base amount shall be selected progressively by trial and error until the sum of the LIDSH payments to hospitals equals the appropriated amount.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5100 Payment method—MIDSH. (1) The department shall deem a hospital eligible for the medically indigent disproportionate share hospital (MIDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is an in-state or border area hospital;

(c) Provides services to clients under the medically indigent program; and

(d) Has a low-income utilization rate of one percent or more.

(2) The department shall determine the MIDSH payment for each eligible hospital in accordance with WAC 388-550-4800.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5100, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5150 Payment method—GAUDSH.

(1) The department shall deem a hospital eligible for the general assistance-unemployable disproportionate share hospital (GAUDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is an in-state or border area hospital;

(c) Provides services to clients under the medical care services program; and

(d) Has a low-income utilization rate (LIUR) of one percent or more.

(2) The department shall determine the GAUDSH payment for each eligible hospital in accordance with WAC 388-550-4800, except that the payment shall not be reduced by the additional three percent specified in WAC 388-550-4800(4).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5200 Payment method—SRHAPDSH. (1) The department shall deem a hospital eligible for the small rural hospital assistance program disproportionate share hospital (SRHAPDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is an in-state hospital;

(c) Is a small, rural hospital, defined as a hospital with fewer than seventy-five licensed beds and located in a city or town with a nonstudent population of thirteen thousand or less; and

(d) Provides at least one percent of its services to low-income patients in rural areas of the state.

(2)(a) The department shall pay hospitals qualifying for SRHAPDSH payments from a legislatively appropriated pool.

(b) The department shall determine each individual hospital's SRHAPDSH payment as follows: The total dollars in the pool will be multiplied by the percentage derived from dividing the Medicaid payments to the individual hospital during the fiscal year that is two years previous to the state fiscal year immediately preceded by the total Medicaid payments to all SRHAPDSH hospitals during the same hospital fiscal year.

(3) The department's SRHAPDSH payments to a hospital may not exceed one hundred percent of the projected cost of care for Medicaid and uninsured indigent patients. The department shall reallocate dollars not allocated because a hospital would otherwise exceed this ceiling to the remaining hospitals in the SRHAPDSH pool.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5250 Payment method—THAPDSH.

(1) The department shall deem a hospital eligible for the teaching hospital assistance program disproportionate share hospital (THAPDSH) program if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is a Washington State University hospital; and

(c) Has a Medicaid inpatient utilization rate (MIPUR) of twenty percent or more.

(2) The department shall fund THAPDSH payments with legislatively appropriated monies. The department shall divide the legislatively appropriated THAPDSH amount equally between qualifying hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5300 Payment method—STHFPDSH.

(1) The department shall deem a hospital eligible for the state teaching hospital financing program disproportionate share hospital (STHFPDSH) if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is a state-owned university or public corporation hospital (border area hospitals are excluded);

(c) Provides a major medical teaching program, defined as a hospital with more than one hundred residents and/or interns; and

(d) Has a Medicaid inpatient utilization rate (MIPUR) of at least twenty percent.

(2)(a) The department shall pay hospitals deemed eligible under the criteria in subsection (1) of this section a STHFPDSH payment from the legislatively appropriated pool specifically designated for DSH payments to state and county teaching hospitals.

(b) The department shall limit STHFPDSH payments to eligible hospitals to seventy percent of the legislatively

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appropriated pool for DSH payments to state and county teaching hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5350 Payment method—CTHFPDSH.

(1) The department shall deem a hospital eligible for the county teaching hospital financing program disproportionate share hospital (CTHFPDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is a county hospital in Washington state (border area hospitals are excluded), so designated by the county in which located;

(c) Provides a major medical teaching program, defined as a hospital with more than one hundred residents and/or interns; and

(d) Has a low-income utilization rate (LIUR) of at least twenty-five percent.

(2)(a) The department shall pay hospitals deemed eligible under the criteria in subsection (1) of this section a CTHFPDSH payment from the legislatively appropriated pool specifically designated for DSH payments to state and county teaching hospitals.

(b) The department shall limit CTHFPDSH payments to eligible hospitals to thirty percent of the legislatively appropriated pool for DSH payments to state and county teaching hospitals.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5400 Payment method—PHDDSH.

(1) The department shall deem a hospital eligible for the public hospital district disproportionate share hospital (PHDDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900 (2)(c) and (4);

(b) Is a public district hospital in Washington state or a border area hospital owned by a public corporation; and

(c) Provides at least one percent of its services to low-income patients.

(2) The department shall pay hospitals deemed eligible under the criteria in subsection (1) of this section a PHDDSH payment amount from the legislatively appropriated PHDDSH pool.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5500 Payment—Hospital-based

RHCs. (1) The department shall reimburse hospital-based rural health clinics under the prospective payment methods effective July 1, 1994. Under the prospective payment method, the department shall not make reconciliation payments to a hospital-based rural health clinic to cover its costs for a preceding period.

(2) The department shall pay an amount equal to the hospital-based rural health clinic's charge multiplied by the hos-

pital's specific ratio of costs to charges (RCC), not to exceed one hundred percent of the charges.

(3) The department shall determine the hospital-based rural health clinic's RCC from the hospital's annual Medicare cost report, pursuant to WAC 388-550-4500(1).

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5550 Public notice for changes in Medicaid payment rates for hospital services. (1) The purpose and intent of this section is to describe the manner in which the department, pertaining to Medicaid hospital rates, will comply with section 4711(a) of the federal Balanced Budget Act of 1997, Public Law 105-33, as codified at 42 U.S.C. 1396a (a)(13)(A).

(2) For purposes of this section, the term:

(a) "Stakeholders" means providers, beneficiaries, representatives of beneficiaries, and other concerned state residents.

(b) "Rate" means the Medicaid payment amount to a provider for a particular hospital service, except for disproportionate share payments not mandated by federal law.

(c) "Methodology" underlying the establishment of a Medicaid hospital rate means (unless otherwise noted) the principles, procedures, limitations, and formulas detailed in WAC 388-550-2800 through 388-550-5500.

(d) "Justification" means an explanation of why the department is proposing or implementing a Medicaid rate change based on a change in Medicaid rate-setting methodology.

(e) "Reasonable opportunity to review and provide written comments" means a period of fourteen calendar days in which stakeholders may provide written comments to the department.

(f) "Hospital services" means those services that are performed in a hospital facility for an inpatient client and which are payable only to the hospital entity, not to individual performing providers.

(g) "Web site" means the department's internet home page on the worldwide web: <http://www.wa.gov/dshs/maa> is the internet address.

(3) The department will notify stakeholders of proposed and final changes in individual Medicaid hospital rates for hospital services, as follows:

(a) Publish the proposed Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates;

(b) Give stakeholders a reasonable opportunity to review and provide written comments on the proposed Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates; and

(c) Publish the final Medicaid hospital rates, the methodologies underlying the establishment of such rates, and justifications for such rates.

(4)(a) Except as otherwise provided in this section, the department will determine the manner of publication of proposed or final Medicaid hospital rates.

(b) Publication of proposed Medicaid hospital rates will occur as follows:

(i) The department will mail each provider's proposed rate to the affected provider via first-class mail at least fifteen calendar days before the proposed date for implementing the rates; and

(ii) For other stakeholders, the department will post proposed rates on the department's web site.

(c) Publication of final Medicaid hospital rates will occur as follows:

(i) The department will mail each provider's final rate to the affected provider via first-class mail at least one calendar day before implementing the rate; and

(ii) For other stakeholders, the department will post final rates on the department's web site.

(d) The publications required by subsections (4)(b) and (c) of this section will refer to the appropriate sections of chapter 388-550 WAC for information on the methodologies underlying the proposed and final rates.

(5) The department, whenever it proposes amendments to the methodologies underlying the establishment of Medicaid hospital rates as described in WAC 388-550-2800 through 388-550-5500, will adhere to the notice and comment provisions of the Administrative Procedure Act (chapter 34.05 RCW).

(6) Stakeholders who wish to receive notice of either proposed and final Medicaid hospital rates or proposed and final amendments to WAC 388-550-2800 through 388-550-5500 must notify the department in writing. The department will send notice of all such actions to such stakeholders postage prepaid by regular mail.

(7)(a) The notice and publication provisions of section 4711(a) of the Balanced Budget Act of 1997 do not apply when a rate change is:

(i) Necessary to conform to Medicare rules, methods, or levels of reimbursement for clients who are eligible for both Medicare and Medicaid;

(ii) Required by Congress, the legislature, or court order, and no further rulemaking is necessary to implement the change; or

(iii) Part of a non-Medicaid program.

(b) Although notice and publication are not required for Medicaid rate changes described in subsection (7)(a) of this section, the department will attempt to timely notify stakeholders of these rate changes.

(8) The following rules apply when the department and an individual hospital negotiate or contractually agree to Medicaid rates for hospital services:

(a) Receipt by the hospital of the contract or contract amendment form for signature constitutes notice to the hospital of proposed Medicaid rates.

(b) Receipt by the hospital of the contract or contract amendment form signed by both parties constitutes notice to the hospital of final Medicaid rates.

(c) Notwithstanding subsection (4)(c) of this section, final Medicaid contract rates are effective on the date contractually agreed to by the department and the individual hospital.

(d) Prior to the execution of the contract, the department will not publish negotiated contract prices that are agreed to between the department and an individual provider to anyone other than the individual provider. Within fifteen calendar

days after the execution of any such contract, the department will publish the negotiated contract prices on its web site.

(9) The following rules apply when a hospital provider or other stakeholder wishes to challenge the adequacy of the public notification process followed by the department in proposing or implementing a change to Medicaid hospital rates, the methodologies underlying the establishment of such rates, or the justification for such rates:

(a) If any such challenge is limited solely to the adequacy of the public notification process, then the challenge will:

(i) Not be pursued in any administrative appeal or dispute resolution procedure established in rule by the department; and

(ii) Be pursued only in a court of proper jurisdiction as may be provided by law.

(b) If a hospital provider brings any such challenge in conjunction with an appeal of its Medicaid rate, then the hospital provider may pursue the challenge in an administrative appeal or dispute resolution procedure established in rule by the department under which hospital providers may appeal their Medicaid rates.

[Statutory Authority: RCW 74.09.500 and 42 USC 1396a (a)(13)(A). 98-23-036, § 388-550-5550, filed 11/10/98, effective 12/11/98.]

WAC 388-550-5600 Hospital rate appeals and disputes. (1) A hospital may appeal any aspect of its Medicaid payment rates by submitting a written notice of appeal and supporting documentation to the medical assistance administration's (MAA) hospital reimbursement section, except that no administrative appeals may be filed challenging the method described herein.

(a) The grounds for rate adjustments include, but are not limited to:

(i) Errors or omissions in the data used to establish rates; and

(ii) Peer group change recommended by the Washington state department of health.

(b) The department may require additional documentation from the provider in order to complete the appeal review. The department may conduct an audit and/or desk review if necessary to complete the appeal review.

(c) Unless the written rate notification specifies otherwise, a hospital shall file an appeal within sixty days after being notified of an action or determination the hospital wishes to challenge. The department shall deem the notification date of an action or determination the date of the written rate notification letter.

(i) A hospital which files an appeal within the sixty-day period described in subsection (1)(c) of this section shall be eligible for retroactive rate adjustments if it prevails.

(ii) The department shall not consider a hospital rate appeal filed after the sixty-day period described in this subsection for retroactive rate adjustments.

(d) When a hospital appeals a rate the department may review all aspects of its rate.

(e) Unless the written rate notification specifies otherwise, the department shall deem rate changes resulting from an appeal effective as follows:

(i) Increases in rates resulting from an appeal filed within sixty days after the written rate notification letter that the hospital is challenging shall be effective retroactive to the date of the rate change specified in the original notification letter.

(ii) Increases in rates resulting from a rate appeal filed after the sixty day period or exception period shall be effective on the date the appeal was filed with the department.

(iii) A rate decrease resulting from an appeal shall be effective on the date specified in the appeal decision notification.

(2)(a) A hospital may request a dispute conference to appeal an administrative review decision. The conference shall be conducted by the assistant secretary for the MAA or his/her designee.

(b) The hospital shall submit a request for a conference within thirty days of receipt of the administrative review decision.

(c) The department shall deem the dispute conference decision its final decision regarding rate appeals.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5700 Hospital reports and audits. (1) In-state and border area hospitals shall complete and submit a copy of their annual Medicare cost reports (HCFA 2552) to the department. These hospital providers shall:

(a) Maintain adequate records for audit and review purposes, and assure the accuracy of their cost reports;

(b) Complete their annual Medicare HCFA 2552 cost report according to the applicable Medicare statutes, regulations, and instructions; and

(c) Submit a copy to the department:

(i) Within one hundred fifty days from the end of the hospital's fiscal year; or

(ii) If the hospital provider's contract is terminated, within one hundred fifty days of effective termination date; or

(d) Request up to a thirty day extension of the time for submitting the cost report in writing at least ten days prior to the due date of the report. Hospital providers shall include in the extension request the completion date of the report, and the circumstances prohibiting compliance with the report due date;

(2) If a hospital provider improperly completes a cost report or the cost report is received after the due date or approved extension date, the department may withhold all or part of the payments due the hospital until the department receives the properly completed or late report.

(3) Hospitals shall submit other financial information required by the department to establish rates.

(4) The department shall periodically audit:

(a) Cost report data used for rate setting;

(b) Hospital billings; and

(c) Other financial and statistical records.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5700, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5800 Outpatient and emergency hospital services. The department shall cover outpatient services, emergent outpatient surgical care, and other emergency care performed on an outpatient basis in a hospital for categorically needy or limited casualty program-medically needy clients. The department shall limit clients eligible for the medically indigent program to emergent hospital services, subject to the conditions and limitations of WAC 388-521-2140, 388-529-2950, and this chapter.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5800, filed 12/18/97, effective 1/18/98.]

WAC 388-550-5900 Prior authorization—Outpatient services. The department shall require providers to obtain prior authorization for the following selected outpatient hospital services:

- (1) Magnetic resonance imaging;
- (2) Magnetic resonance angiography;
- (3) Sleep studies/polysomnograms for clients over one year old, unless provided in a medical assistance administration (MAA)-approved facility;
- (4) Peripheral stem cell transplants, unless provided in an MAA-approved facility;
- (5) Positron emission tomography scans, except that the department shall not require prior authorization for brain PET scans;
- (6) Evaluation, management and treatment of chronic pain, unless provided in an MAA-approved facility; and
- (7) Weight loss program costs, unless provided in a department-approved outpatient weight-loss facility.
- (8) See WAC 388-550-1700 for hospital services requiring prior approval and WAC 388-550-1800 for certain prior approval exemptions.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-5900, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6000 Payment—Outpatient hospital services. (1)(a) The department shall determine allowable costs for hospital outpatient services, excluding nonallowable revenue codes, by the application of the hospital-specific outpatient ratio of costs to charges (RCC), except as specified in subsection (2) below.

(b) The department shall not pay separately for ancillary hospital services which are included in the hospital's RCC reimbursement rate.

(2) The department shall pay the lesser of billed charges or the department's published maximum allowable fees for the following outpatient services:

- (a) Laboratory/pathology;
- (b) Radiology, diagnostic and therapeutic;
- (c) Nuclear medicine;
- (d) Computerized tomography scans, magnetic resonance imaging, and other imaging services;
- (e) Physical therapy;
- (f) Occupational therapy;
- (g) Speech/language therapy; and
- (h) Other hospital services as identified and published by the department.

(3) The department shall not be responsible for payment of hospital care and/or services provided to a client enrolled in a department-contracted, prepaid medical plan when the client fails to use:

- (a) For a nonemergent condition, a hospital provider under contract with the plan;
- (b) In a bona fide emergent situation, a hospital provider under contract with the plan; or
- (c) The provider whom the department has authorized to provide and receive payment for a service not covered by the prepaid plan but covered under the client's medical assistance program.

(4) The department shall consider a hospital stay of twenty-four hours or less as an outpatient short stay. The department shall not reimburse an outpatient short stay under the diagnosis-related group system except when it involves one of the following situations:

- (a) Death of a client;
- (b) Obstetrical delivery;
- (c) Initial care of a newborn; or
- (d) Transfer of a client to another acute care hospital.

(5) The department shall not pay for patient room and ancillary services charges beyond the twenty-four period for outpatient stays.

(6) The department shall not cover short stay unit, emergency room facility charges, and labor room charges in combination when the billed periods overlap.

(7) The department shall require that the hospital's bill to the department shows the admitting, principal, and secondary diagnoses, and include the attending physician's name.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6000, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6100 Outpatient hospital physical therapy. (1) The department shall pay for physical therapy as an outpatient hospital service when:

- (a) The attending physician prescribes physical therapy;
- (b) A licensed physical therapist or physiatrist or a physical therapist assistant supervised by a licensed physical therapist provides the treatment; and
- (c) The therapy assists the client:
 - (i) In avoiding hospitalization or nursing facility care; or
 - (ii) In becoming employable; or
 - (iii) Who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
 - (iv) As part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

(2) The hospital shall bill outpatient hospital physical therapy services to the department using the appropriate current procedural terminology or department-assigned codes. The department shall not pay outpatient hospitals a facility fee for such services.

(3) The department shall pay for outpatient hospital physical therapy for clients eligible under the:

- (a) Categorically needy, general assistance unemployed and ADATSA programs;
- (b) Medically needy program only when the client is:

(i) Twenty years of age and under and referred by a screening provider under the early and periodic screening, diagnosis, and treatment program; or

(ii) Receiving home health care services.

(4) The department shall not pay for physical therapy programs for clients under the limited casualty program-medically indigent program.

(5)(a) For clients who are twenty years of age or under, the department shall not require prior authorization or limit the number of physical therapy sessions payable per client per calendar year, subject to the provision of subsection (8) below, provided the services are medically necessary.

(b) Providers shall fully document in the client's medical record the medical justification for continued therapy.

(6)(a) Except as provided in subsection (7) below, the department shall pay for categorically needy, medically needy and medical care services clients who are twenty-one years of age or older a total of eighteen hours of physical therapy in a calendar year, in any combination of modalities and procedures, for:

(i) Acute conditions; or

(ii) Following joint surgery.

(b) The department shall set time unit equivalents for each physical therapy procedure or modality, and publish such schedules periodically.

(7) For a client twenty-one years of age or older who has a medical diagnosis specified in the outpatient hospital billing instructions as normally requiring more intensive physical therapy treatment, the department shall cover up to twenty-four hours of physical therapy in a calendar year, in any combination of modalities and procedures.

(8)(a) Notwithstanding the hours per calendar year limit, the department shall reimburse a maximum of one hour of physical therapy session per day, except that a maximum of two hours shall be allowed when a client assessment/evaluation is performed on the same date.

(b) The physical therapy provider shall document in each client's record the amount of time spent on services to the client.

(9)(a) The department shall require that physical therapy begin within thirty days of the date the therapy was prescribed.

(b) The department may deny payment for therapy started more than thirty days after the date of the prescription, unless medical justification for the delay is presented to the department.

(c) The hospital shall include the prescription for physical therapy services in the client's medical record.

(10) The department shall not pay for physical therapy services under fee-for-service when physical therapy is already included in other reimbursement methodologies applied to the case, including but not limited to DRG payment for inpatient hospital services and nursing facility per diem.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6100, filed 12/18/97, effective 1/18/98.]

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WAC 388-550-6150 Outpatient hospital occupational therapy. (1) The department shall pay for occupational therapy as an outpatient hospital service when:

(a) The service is provided by a licensed occupational therapist or a licensed occupational therapy assistant supervised by a licensed occupational therapist;

(b) The provider obtains approval from the department before services are performed, for services requiring prior approval as designated in the department's billing instructions; and

(c) The occupational therapy is provided:

(i) As part of an outpatient program when identified in the early and periodic screening, diagnosis, and treatment program of a recipient twenty years of age and younger; or

(ii) As part of the physical medicine and rehabilitation program.

(2)(a) The hospital shall bill outpatient hospital occupational therapy services to the department using the appropriate current procedural terminology or department-assigned codes.

(b) The department shall not pay outpatient hospitals a facility fee for these services.

(3) The department shall pay for occupational therapy provided to clients eligible under the:

(a) Categorically needy, general assistance unemployed and ADATSA programs;

(b) Medically needy program only when the client is:

(i) Twenty years of age and younger and referred by a screening provider under the early and periodic screening, diagnosis and treatment program; or

(ii) Receiving home health care services.

(4) The department shall reimburse for occupational therapy as part of an outpatient program when identified in the early and periodic screening, diagnosis, and treatment program of an eligible client.

(5) The department shall cover one assessment, two durable medical equipment needs assessments, and twelve sessions of outpatient hospital occupational therapy per year.

(6) The department shall pay for up to twenty-four additional therapy visits for clients under the children with special health care needs program when the therapy visits are related to the approved list of diagnoses as published by the department.

(7) The department shall not pay for occupational therapy when payment for occupational therapy is included in the reimbursement of other treatment programs including, but not limited to the hospital inpatient diagnosis related group and inpatient physical medicine and rehabilitation services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6150, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6200 Outpatient hospital speech therapy services. (1) The department shall cover speech therapy services for eligible medical care clients who have a medically recognized disease or defect which requires speech therapy services, except as limited below:

(a) Under the medically needy program the department shall limit therapy to clients twenty years of age and under.

(b) The department shall not pay for specialized speech therapy under the medically indigent program.

(2) The department shall cover speech therapy when provided under a written plan of treatment:

(a) Established by a speech pathologist who has been granted a certificate of clinical competence by the American Speech, Language and Hearing Association; or

(b) An individual who has completed the equivalent educational and work experience necessary for such a certificate; and

(c) That is periodically reviewed by the client's primary care physician.

(3) The department shall cover one medical diagnostic evaluation and twelve speech therapy sessions in a calendar year per client. The department may cover up to twenty-four additional speech therapy sessions only when associated with the specific diagnoses listed in the department's outpatient hospital billing instructions. The department shall make such instructions available to the public.

(4) The department shall require a provider to submit an authorization request to the office of children with special health care needs on the appropriate form for a child with special health care needs who needs more than twelve speech therapy sessions or the additional twenty-four sessions, but does not have any of the specific diagnoses identified in subsection (3) of this section.

(5) The department shall require swallowing (dysphagia) evaluations to be performed by a speech/language pathologist who holds a master's degree in speech pathology and who has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

(6) The department shall require a swallowing evaluation to include:

(a) An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;

(b) Dietary recommendations for oral food and liquid intake therapeutic or management techniques;

(c) Therapeutic or management techniques; and

(d) Videofluoroscopy, when necessary, for further evaluation of swallowing status and aspiration risks.

(7) The provider shall bill outpatient hospital speech therapy services to the department using the appropriate current procedural terminology or department-assigned codes. The department shall not pay the outpatient hospital a facility fee for these services.

(8) The department shall not pay for speech therapy when payment for speech therapy is included in the reimbursement as part of other treatment programs including, but not limited to the hospital inpatient diagnosis-related group and nursing facility services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6200, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6250 Pregnancy—Enhanced outpatient benefits. The department shall provide outpatient chemical dependency treatment in programs qualified under chapter 440-25 WAC and certified under chapter 440-22 WAC or its successor.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6250, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6300 Outpatient nutritional counseling.

(1) The department shall cover nutritional counseling services only for eligible Medicaid clients twenty years of age and under referred during an early and periodic screening, diagnosis and treatment screening to a certified dietitian.

(2) Except for children under the children's medical program, the department shall not cover nutritional counseling for clients under the medically indigent and other state-only funded programs.

(3) The department shall pay for nutritional counseling for the following conditions:

(a) Inadequate or excessive growth such as failure to thrive, undesired weight loss, underweight, major change in weight-to-height percentile, and obesity;

(b) Inadequate dietary intake, such as formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite;

(c) Infant feeding problems, such as poor suck/swallow reflex, breast-feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited caregiver knowledge and/or skills;

(d) Chronic disease requiring nutritional intervention, such as congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, and gastrointestinal disease;

(e) Medical conditions requiring nutritional intervention, such as iron-deficiency anemia, familial hyperlipidemia, and pregnancy;

(f) Developmental disability, such as increasing the risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings; or

(g) Psycho-social factors, such as behavior suggesting eating disorders.

(4) The department shall pay for maximum of twenty sessions, in any combination, of assessment/evaluation and/or nutritional counseling in a calendar year.

(5) The department shall require each assessment/evaluation or nutritional counseling session be for a period of twenty-five to thirty minutes of direct interaction with a client and/or the client's caregiver.

(6) The department shall pay the provider for a maximum of two sessions per day per client.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6300, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6350 Outpatient sleep apnea/sleep study programs. (1) The department shall pay for polysomnograms or multiple sleep latency tests only for clients one year of age or older with obstructive sleep apnea or narcolepsy.

(2) The department shall pay for polysomnograms or multiple sleep latency tests only when performed in outpatient hospitals approved by the medical assistance administration (MAA) as centers of excellence for sleep apnea/sleep study programs.

(3) The department shall not require prior authorization for sleep studies as outlined in WAC 388-550-1800.

(4) Hospitals shall bill the department for sleep studies using current procedural terminology codes. The department shall not reimburse hospitals for these services when billed under revenue codes.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6350, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6400 Outpatient hospital diabetes education. (1) The department shall pay for outpatient hospital-based diabetes education for an eligible client when:

(a) The facility is approved by the department of health (DOH) as a diabetes education center, and

(b) The client is referred by a licensed health care provider.

(2) The department shall require the diabetes education teaching curriculum to have measurable, behaviorally-stated educational objectives. The diabetes education teaching curriculum shall include all the following core modules:

(a) An overview of diabetes;

(b) Nutrition, including individualized meal plan instruction that is not part of the Women, Infants, and Children program;

(c) Exercise, including an individualized physical activity plan;

(d) Prevention of acute complications, such as hypoglycemia, hyperglycemia, and sick day management;

(e) Prevention of other chronic complications, such as retinopathy, nephropathy, neuropathy, cardiovascular disease, foot and skin problems;

(f) Monitoring, including immediate and long term diabetes control through monitoring of glucose, ketones, and glycosylated hemoglobin; and

(g) Medication management, including administration of oral agents and insulin, and insulin start-up.

(3) The department shall pay for a maximum of six hours of individual core survival skills outpatient diabetes education per lifetime per client.

(4) The department shall require DOH-approved centers to bill the department for diabetes education services on the UB92 billing form using the specific revenue codes assigned and published by the department.

(5) The department shall reimburse for outpatient hospital-based diabetes education based on the individual hospital's current specific ratio of costs-to-charges, or the hospital's customary charge for diabetes education, whichever is less.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6400, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6450 Outpatient hospital weight loss program. The department may pay for an outpatient weight loss program only when provided through an outpatient weight loss facility approved by the medical assistance administration. The department shall deny payment for services provided by nonapproved providers.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6450, filed 12/18/97, effective 1/18/98.]

(1999 Ed.)

WAC 388-550-6500 Blood and blood products. (1) The department shall limit Medicaid reimbursement to a hospital for blood derivatives to blood bank service charges for processing the blood and blood products.

(2) Other than payment of blood bank service charges, the department shall not pay for blood and blood derivatives.

(3) The department shall not separately reimburse blood bank service charges for handling and processing blood and blood derivatives provided to an individual who is hospitalized when the hospital is reimbursed under the diagnosis-related group (DRG) system. The department shall bundle these service charges into the total DRG payment.

(4) The department shall reimburse a hospital, which is paid under the cost to charge method, separately for processing blood and blood products.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6500, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6600 Hospital-based physician services. See chapter 388-531 WAC regarding rules for inpatient and outpatient physician services.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-6700 Hospital services provided out-of-state. (1) The department shall reimburse only emergency care for an eligible Medicaid client who goes to another state, except specified border cities, specifically for the purpose of obtaining medical care that is available in the state of Washington. See WAC 388-501-0175 for a list of border cities.

(2) The department shall authorize and provide comparable medical care services to a Medicaid client who is temporarily outside the state to the same extent that such medical care services are furnished to an eligible Medicaid client in the state, subject to the exceptions and limitations in this section.

(3) The department shall not authorize payment for out-of-state medical care furnished to state-funded clients (medically indigent/medical care services), but may authorize medical services in designated bordering cities.

(4) The department shall cover hospital care provided to Medicaid clients in areas of Canada as described in WAC 388-501-0180 (1)(b).

(5) The department shall review all cases involving out-of-state medical care to determine whether the services are within the scope of the medical assistance program.

(6)(a) If the client can claim deductible or coinsurance portions of Medicare, the provider shall submit the claim to the intermediary or carrier in the provider's own state on the appropriate Medicare billing form.

(b) If the state of Washington is checked on the form as the party responsible for medical bills, the intermediary or carrier may bill on behalf of the provider or may return the claim to the provider for submission to the state of Washington.

(7) For reimbursement for out-of-state inpatient hospital services, see WAC 388-550-4000.

(8) The department shall reimburse out-of-state outpatient hospital services billed under the physician's current procedural terminology codes at an amount that is the lower of:

- (a) The billed amount; or
- (b) The rate paid by the Washington state Title XIX Medicaid program.

(9) Out-of-state providers shall present final charges to MAA within three hundred sixty-five days of the date of service. In no case shall the state of Washington be liable for payment of charges received beyond one year from the date services were rendered.

[Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-6700, filed 12/18/97, effective 1/18/98.]

Chapter 388-555 WAC INTERPRETER SERVICES

WAC

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388-555-1450	Services at federally qualified health clinics.

WAC 388-555-1000 Definitions. For the purposes of this chapter, the following definitions apply:

"Client" means any individual who has been determined eligible for medical or health care services for any of the medical assistance administration (MAA) programs.

"Consecutive appointments" means appointments beginning or scheduled to begin within fifteen minutes of the last completed appointment.

"Family member" means any person who is related to the client: a spouse, child, grandmother, grandfather, grandchild, mother, father, sister, brother, cousin, niece, nephew, aunt, uncle, step relations and/or in-laws.

"Federally qualified health center" (FQHC) means:

(1) A facility that is receiving grants under section 329, 330, or 340 of the Public Health Services Act; or

(2) Receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service as determined by the secretary to meet the requirements for receiving such a grant; or

(3) A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (P.L. 93-638). Only Health Care Financing Administration-designated FQHCs will be allowed to participate in MAA's Medicaid program.

"Independent interpreter" means any fluent, bilingual/multilingual person, certified by language interpretation services and translation (LIST) in medical terminology, who provides interpreter services for payment and who is not employed by, or a contractor of, any interpreter agency enrolled with MAA. Independent interpreter also means any person fluent in American Sign Language, certified by the

National Association for the Deaf (NAD) or Registry for Interpreters for the Deaf (RID).

"Interpreter" means a person who speaks English and another language fluently or signs American Sign Language fluently. Fluency includes an understanding of nonverbal and cultural patterns necessary to communicate effectively. An interpreter enables clients and medical/health care providers to communicate effectively with each other.

"Interpreter agency" means a business entity, organized under and permitted to operate by the laws of the state of Washington, which offers as one of its main objectives or purposes to procure interpreter services by employing or contracting with bilingual/multilingual persons on a permanent or part-time basis to provide medical interpreter services for payment to MAA clients. For purposes of this chapter, interpreter agency does not include:

(1) A business entity that employs a person exclusively or regularly to perform other duties, or to perform interpreter services solely in connection with the affairs of that employer; or

(2) A person who is self-employed and is the only bilingual/multilingual employee contracting for the purpose of providing interpreter services to others.

"Language interpretation services and translation" (LIST) means the section within the department of social and health services (DSHS) that is responsible for certifying and qualifying spoken language interpreters.

"Limited English proficient (LEP)" means a limited ability or an inability to speak, read, or write English well enough to understand and communicate effectively in normal daily activities. The client decides whether he/she is limited in his/her ability to speak, read, or write English.

"Primary language" means the language identified by the client as the language in which he/she wishes to communicate. This may also be referred to as the preferred language.

"Qualified interpreter for American Sign Language" means a certified NAD, RID, or noncertified interpreter who is determined to be competent, both receptively and expressively by the consumer to be qualified to effectively meet his/her communication needs, both receptively and expressively.

"Qualified interpreter for spoken languages" means an interpreter who has passed DSHS screening tests in languages other than the DSHS certificated languages as specified in RCW 74.04.025.

"Unit" means a billable amount of time for interpreter services equal to fifteen minutes.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1000, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1050 Covered services. Interpreters and/or interpreter agencies shall receive payment for interpreter services that are:

- (1) Provided for a client who is:
- (a) Deaf;
- (b) Deaf-blind;
- (c) Hard of hearing; or
- (d) Limited English proficient.

- (2) Provided during a necessary medical service performed by an eligible provider; and
- (3) Covered under a MAA program for which the client is eligible. For exceptions, see WAC 388-555-1100, Non-covered services.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1050, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1100 Noncovered services. Interpreters and/or interpreter agencies shall not receive payment from MAA for interpreter services related to:

- (1) Inpatient hospital services;
- (2) Nursing facility services;
- (3) Community mental health center services;
- (4) The provision of any noncovered service;
- (5) Interpreter services funded or paid for by any other source;
- (6) Interpreter services provided by an interpreter to the interpreter's own family members;
- (7) Any person other than an eligible MAA client;
- (8) Medical assistance client no-shows;
- (9) The interpreter's failure to appear for scheduled services;
- (10) The interpreter's transportation costs or travel time;
- (11) Waiting time before the scheduled appointment; or
- (12) Any block of time when interpreter services are not required by the medical provider to communicate with a medical assistance client.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1100, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1150 Eligible providers. (1) To provide services other than at FQHCs, independent interpreters and/or interpreter agencies are considered eligible providers when they:

- (a) Are enrolled with MAA to provide interpreter services;
- (b) Meet the criteria in WAC 388-87-007, Medical provider agreement, and WAC 388-87-010, Conditions of payment—General.
- (2) To enroll as an independent interpreter for MAA clients, interpreters shall submit the following to the department:

 - (a) Proof of certification which may be either:

 - (i) Number and date of medical certificate from LIST; or
 - (ii) A copy of a RID or NAD certificate for certified sign language interpreters.

 - (b) A Social Security Number, if the interpreter has one;
 - (c) A completed interpreter services core provider agreement;
 - (d) A signed confidentiality pledge;
 - (e) A completed provider information form; and
 - (f) Verification of errors and omissions liability insurance at or over one hundred thousand dollars per occurrence.

- (3) To enroll with MAA as an interpreter agency, the agency shall submit to the department:

 - (a) A completed interpreter services core provider agreement;

(1999 Ed.)

(b) Verification of errors and omissions liability insurance at or over one million dollars per occurrence;

(c) A completed provider information form; and

(d) A list of interpreters employed/contracted to provide services to MAA clients, including the following information for each interpreter:

- (i) A signed confidentiality pledge; and
- (ii) Number and date of medical certificate from LIST;

or

(iii) A copy of a current RID or NAD certificate for certified sign language interpreters or written description of evaluation process for qualified interpreter status.

(4) To qualify as an eligible provider, an interpreter agency shall have the capacity to provide interpreter services in:

- (a) American Sign Language; or
- (b) At least three spoken languages; or

(c) Fewer than three spoken languages if the languages provided are reflective of a majority of the LEP clients residing within the county(ies) served by the agency. DSHS reports will be used to identify the languages needed in the demographic area.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1150, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1200 Provider requirements. (1) An interpreter or interpreter agency shall not determine the need for interpreter services, nor shall the interpreter market interpreter services to MAA clients. See WAC 388-555-1250, Coordination of services.

(2) An interpreter or interpreter agency shall not require a client to obtain interpreter services exclusive of other interpreters or interpreter agencies.

(3) An interpreter or interpreter agency shall adhere to department policies and procedures regarding confidentiality of client records as stated in WAC 388-501-0150.

(4) An independent interpreter shall enroll with the department as provided in WAC 388-555-1100 and obtain a current medical assistance provider number.

(5) An interpreter or interpreter agency must participate in an orientation which will be scheduled and given by MAA within their first year of contracting with the department. The department may terminate contracts with any provider who does not participate in the orientation.

(6) Interpreter agencies shall assume full legal and financial liability for interpreter services provided by employees and contractors.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1200, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1250 Coordination of services. An interpreter and/or interpreter agency shall:

(1) Coordinate appointment dates and times with the medical provider and the client as requested by the medical provider; and

(2) Notify the medical provider of any changes to scheduled appointments at least twenty-four hours in advance.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1250, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1300 Payment. (1) Eligible interpreters and/or interpreter agencies shall only provide services when the following conditions are met:

(a) The client or the medical provider determines that an interpreter is necessary in order for the client to appropriately access necessary medical and health care services covered by the client's medical assistance program;

(b) The medical provider has informed the client that interpreter services are available at no cost to the client; and

(c) The interpreter presents a current identification card with his/her name, such as a driver's license, prior to providing interpreter services.

(2) To the extent permitted under federal law and regulation, the department may provide federal financial participation to match funds expended by public agencies for interpreter services.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1300, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1350 Payment methodology. (1) An interpreter and/or interpreter agency providing services at facilities other than FQHCs shall receive payment for interpreter services based on:

(a) Funds legislatively provided for interpreter services;

(b) Department allocation of vendor rate increases appropriated by the legislature;

(c) Billable units of time; and

(d) Submitting claims to the department according to billing instructions provided by MAA. All eligible interpreters will be provided with billing instructions.

(2) An interpreter and/or interpreter agency providing services at an FQHC shall seek payment according to WAC 388-55-1450.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1350, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1400 Recordkeeping and audits. Interpreters and/or interpreter agencies shall maintain legible, accurate, and complete records in order to support and justify interpretation services provided to medical assistance clients. The types of records that must be maintained are described in the billing instructions.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1400, filed 7/10/98, effective 7/10/98.]

WAC 388-555-1450 Services at federally qualified health clinics. (1) A federally qualified health center shall receive payment for interpreter services when the FQHC:

(a) Uses interpreters certified or qualified by LIST; and

(b) Bills MAA fee-for-service.

(2) Interpreters providing services at an FQHC shall:

(a) Be certified and qualified by LIST; and

(b) Meet the requirements described in WAC 388-555-1200 (1), (2) and (3), and 388-555-1250; and

(c) Seek payment from the FQHC.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.04.025, 45 CFR Sec. 80.1 and 80.03; 45 CFR Sec. 605.52; 28 CFR, part 35. 98-15-054, § 388-555-1450, filed 7/10/98, effective 7/10/98.]